FAMILY MEDICAL CENTER OF GEORGETOWN

Full Name: _____ Date of Birth: _____Male/Female

Mailing Address: _____

City: _____ State: _____ Zip: _____

Social Security:_____ D.L. #: _____ State_____ S M W D P

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Emergency Contact: _____ Phone #: _____

**How do you prefer to be contacted regarding upcoming appointments or other medical related matters?

____Cell Phone – Can we leave a detailed message? Yes No

____Home Phone – Can we leave a detailed message? Yes No

____Work Phone – Can we leave a detailed message? Yes No

You may sign up for the patient portal today. This gives you key information in a secure HIPAA-compliant location. You may view and print your Lab results, view Diagnosis, Medications and Immunization History. The patient portal also allows you to exchange messages with your provider instantly, without the need for phone calls and hold times. Please provide your email address to sign up:

Email:_____(see staff regarding your patient health portal PIN)

Other than yourself, list any person(s) you would allow us to give results or other medical information to:

_____ **I DO NOT WISH TO HAVE ANYONE OTHER THAN MYSELF RECEIVE MY MEDICAL INFORMATION.**

OR – Please add names below of persons we are able to discuss your care with:

Name:_____ Relationship: _____ Phone #: _____

Name:_____ Relationship: _____ Phone #: _____

Patient Demographic Information:

Preferred Language_____

Race:_____ Caucasian/White _____Hispanic _____Other (Please specify)_____

Ethnicity:_____

OR

_____ Patient declined to answer

FAMILY MEDICAL CENTER OF GEORGETOWN

Insurance Information

Primary Insurance Name: _____ Copay $_____ or Deductible %_____

Policy/ ID #: _____ Group# _____

Claims Address: _____

_____

Policy Holder Information:

Name: _____ Relationship: _____ of Birth: _____

****If applicable****

Secondary Insurance: _____ Copay $_____ or Deductible %_____

Policy/ ID #: _____ Group# _____

Claims Address: _____

_____

Policy Holder Information:

Name: _____ Relationship: _____ of Birth: _____

Person responsible for payment:

Name_____Date of Birth_____Relation to patient_____

Address:_____City/State/Zip_____

Phone#: _____

PAYMENT: Family Medical Center requires payment at time of service. If you do not have insurance or we do not accept your current insurance, our average new patient charge is $110.00. This does not include any other services that may need to be performed while you are being seen.

CONCERNING INSURANCE: Family Medical Center of Georgetown accepts assignment of benefits from insurance companies with which we are contracted as a participating provider. FAMILY MEDICAL CENTER DOES NOT ACCEPT MEDICAID.

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the treating provider. I understand I am financially responsible for any remaining balance. I also authorize Family Medical Center of Georgetown or my insurance company to release any information required to process my claim.

_____
SIGNATURE OF PATIENT OR RESPONSIBLE GUARDIAN

_____
PRINT PATIENT NAME

_____
PRINT NAME OF PERSON SIGNING (if different from patient)

DATE:_____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Family Medical Center of Georgetown may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Family Medical Center of Georgetown's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Family Medical Center of Georgetown reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Family Medical Center of Georgetown Privacy Officer at 908 Rockmoor Dr., Georgetown, TX 78628.

With my consent, Family Medical Center of Georgetown may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Family Medical Center of Georgetown may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that Family Medical Center of Georgetown restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I state that I have read and understand the Privacy and Policy Procedures of this practice. I am consenting to Family Medical Center of Georgetown's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____

Signature of Patient or Legal Guardian

_____ _____

Print Patient's Name Date

_____

Print Legal Guardian Name

Family Medical Center of Georgetown

Financial Policy

PRIVATE PAY- IF YOU DO NOT HAVE INSURANCE YOU ARE PRIVATE PAY. YOU WILL BE EXPECTED TO PAY FOR YOUR SERVICES AT THE TIME SERVICE IS RECEIVED; UNLESS YOU HAVE MADE PRIOR ARRANGEMENTS WITH THE BILLING OFFICE.

If you have insurance:

INFORMATION VERIFICATION- At check in please be prepared to provide your insurance card and inform the office staff of any changes to your address, phone number, or any other personal information that will be helpful regarding you or your family's account. You may be asked these questions EACH TIME you are seen.

DEDUCTIBLES, CO-PAYMENTS, AND CO-INSURANCE-

- Your copay will be expected each time you are seen; OUR POLICY IS TO COLLECT THIS PAYMENT AT THE TIME OF CHECK IN.
- If deductible applies, OUR OFFICE POLICY IS TO COLLECT A PERCENTAGE of your total charges at the *end* of each visit.
- Most insurance plans are subject to a *deductible* when a procedure is performed in the office (office surgery, etc.). *Co-Insurance* is the amount required by some insurances over and above the deductible or co-payment amount. **You will be billed for deductibles or co-insurance should your insurance company notify our office of any additional amount due by you.** Examples that apply to deductible/ co-insurance include removal of skin tags, moles, warts, etc. as well as DME (braces, splints, etc.).
- Acceptable payment methods include: cash, check and credit/ debit card of Visa, Mastercard, Discover, and American Express.

Your insurance policy is a contract between you, your employer, and the insurance company. **A copy of your insurance card is REQUIRED at the time of your initial service and should be kept current as changes occur.** In order for your claim to process correctly, please ensure that the information that you provide our office on the patient information form is accurate and current and that you provide any changes as they occur. We will file to your insurance as a courtesy and we will submit to secondary insurance as long as we are given the correct information and ask us to do so.

KNOW YOUR BENEFITS- Please be aware that not all services are a covered benefit within your plan.

REFERRALS-

- You are responsible for knowing if a referral is required. *Due to the high volume of requests you should also be prepared to allow our office adequate and reasonable time to arrange for a referral when needed.*
- Make sure you know what physicians are on your plan, what facilities are covered and what ancillary services you must use (such as laboratory, hospitals, etc.).
- Often times, behavioral health benefits are under a separate company and we must contact them in order to verify the necessity of an authorization; AGAIN, stressing the importance of current insurance cards and their phone numbers.

LABORATORY & PATHOLOGY FEES- Sometimes it is necessary to obtain tissue or perform lab tests to confirm a diagnosis or determine the course of treatment. If any tissue is removed for pathology or lab test (blood work, culture, etc.), the actual testing is not done in this office, but sent out. THIS MEANS YOU WILL RECEIVE A SEPARATE BILL FROM ANOTHER DOCTOR OR LABORATORY FOR THESE TESTS.

APPOINTMENTS- Due to the large amount of "NO SHOW" appointments, a $25.00 fee will be charged if the office is not notified one business day prior to the appointment date. Please call the office during the hours of 8:30 am to 6 pm if you should need to cancel.

PAYMENT PLANS-

- We do make payment arrangements for larger balances, but you must speak directly to our billing staff in order to coordinate this agreement.
- Arrangements are NOT made through the front desk staff or nurses.
- If you speak to your provider regarding certain circumstances that may apply, alter, or determine these arrangements, please speak to someone in the billing office as well to keep them aware of the changes happening (such as divorce, loss of job, etc.); or any time arrangements are made directly with the provider.

SPECIAL NOTE- In situations of divorce, separation, court orders, etc. the party initiating treatment will be financially responsible for the account, whether that be copay due at time of service, or deductible/ co-insurance after insurance has been filed. **WE DO NOT GET IN THE MIDDLE OF PERSONAL SITUATIONS.

RETURNED CHECKS- Returned checks are subject to a $25 return check fee. Our office will notify the person/ patient by letter or phone call. If there is no timely response further action will be taken.

COLLECTION EFFORTS- We do understand that temporary financial problems may affect timely payment and we encourage you to communicate any such problems with the billing office so that we can assist you in the management of your account. We will make every effort to work with you to make payment arrangements. Should your account become outstanding, service charges may incur. If all efforts do not bring about a resolution of the account and you receive a "FINAL" letter and statement, the account will be turned over to a collection agency. The fees from the agency will be passed to you in addition to the outstanding balance. **Once your account has been turned over to collections we can no longer accept your payment in our office, and you will no longer be able to make an appointment with your provider.**

Please let us know if you have any questions regarding the policies set fourth, or if we can be of assistance to you.

I have read and understand the policies set fourth be the FAMILY MEDICAL CENTER OF GEORGETOWN.

My signature authorizes this office to file my claims and assigns to this office all rights, title and interest to my medical reimbursements benefits under my insurance policy. I understand that my signature also allows this office to release information regarding my medical records to my insurance carrier. I understand that I am responsible for my bills in the event my insurance company denies a claim.

I ACKNOWLEDGE THAT I HAVE READ AND AGREE TO THE ABOVE FINANCIAL POLICY.

Signature: _____ Date: _____

FAMILY MEDICAL CENTER
of Georgetown

FMC

ADULT HEALTH HISTORY
(HISTORIA DE SALUD DE ADULTO)

First Name (Nombre):	NOTE: This form provides information about your healthcare history, is confidential, and part of your medical record. If you do not understand a question or word, please ask for assistance. *(Este formulario proporciona información sobre su historial médico, es confidencial, y es parte de su archivo médico. Si usted no entiende alguna pregunta o alguna palabra, por favor pida ayuda.)*
Last Name (Apellido):	
Date:	**Race/Ethnicity** (Raza/Etnicidad): / **Preferred Language** (Idioma Preferido):

MEDICAL HISTORY (HISTORIAL MÉDICO)

Diagnosis (Diagnóstico)	Yes (Sí)	No	Diagnosis (Diagnóstico)	Yes (Sí)	No	Diagnosis (Diagnóstico)	Yes (Sí)	No
Anemia (Anemia)			**Diabetes mellitus** (Diabetes mellitus)			**Myocardial infarction** (Infarto de miocardio)		
Anxiety (Asiedad)			**Clotting disorder** (Trastorno de la coagulación)			**Arthritis** (Artritis)		
GERD (Reflujo de acidez Gástrica)			**Asthma** (Asma)			**Seizures** (Convulciones)		
Cancer (Cáncer)			**Heart murmur** (Soplo (murmullo) cardiaco)			**Hepatitis** (Hepatitis)		
Stroke (Derrame cerebral)			**CHF** (Insuficiencia cardiac congestive)			**HIV/AIDS** (VIH/SIDA)		
Hypertension–high blood pressure (Alta presión arterial)			**Thyroid disease** (Enfermedad de la tiroides)			**COPD** (EPOC –enfermedad pulmonar crónica)		
Kidney disease (Enfermedad del riñon)			**Depression** (Depresión)			**High cholesterol** (Alto nivel de cholesterol)		

Other medical history (Otros antecedentes medicos):

SURGICAL HISTORY (ANTECEDENTES QUIRÚRGICOS - CIRUGIAS)

Diagnosis (Diagnóstico)	Yes (Sí)	No	Diagnosis (Diagnóstico)	Yes (Sí)	No	Diagnosis (Diagnóstico)	Yes (Sí)	No
Appendectomy (Apendectomía)			**C-Section** (Cesárea)			**Prostate surgery** (Cirugía de prostate)		
Brain surgery (Cirugía en el cerebro)			**Eye surgery** (Cirugía del ojo)			**Breast surgery** (Cirugía de mama)		
Spine surgery (Cirugía de la columna vertebral)			**CABG** (Bypass coronario depuentes a las arterias coronarias (CABG))			**Hernia repair** (Reparación de hernia)		
Tubal ligation (Ligadura de trompas)			**Cholecystectomy** *(Gallbladder removal)* (Colecistectomía – *extirapación de la vesicula*)			**Hysterectomy** (Histerectomía)		
Valve replacement (Reemplazo de la válvula)			**Colon surgery** (Cirugía de colon)			**Cosmetic surgery** (Cirugía estética)		

Other surgical history (Otros antecedentes quirúrgicos – cirugias):

FAMILY HISTORY (ANTECEDENTES FAMILIARES)

Relationship (Relación)	**Alcohol/Drug** (Alcohol/Drogas)	**Aneurysm** (Aneurisma)	**Asthma** (Asma)	**Breast Cancer** (Cáncer de mama)	**Cancer** (Cáncer)	**Colon Cancer** (Cáncer de colon)	**Coronary artery** (Arteria coronaria)	**Diabetes** (Diabetes)	**Glaucoma** (Glaucoma)	**High Cholesterol** (Hiperlipidemia)	**High Blood Pressure** (Alta presión arterial)	**Kidney disease** (Enfermedad del riñon)	**Macular degeneration** (Degeneración macular)	**Mental Illness** (Enfermedad mental)	**Prostate Cancer** (Cáncer de prostate)	**Rheum. arthritis** (Artritis reumatoidea)	**Stroke** (Derrame cerebral)	**Thyroid disease** (Enfermedad de la tiroides)
Mother (Madre)																		
Father (Padre)																		
Sister (Hermana)																		
Brother (Hermano)																		
Maternal Grandmother (Abuela Materna)																		

Patient Name: Date:

FAMILY HISTORY (ANTECEDENTES FAMILIARES)

Relationship (Relación)	Alcohol/Drug (Alcohol/Drogas)	Aneurysm (Aneurisma)	Asthma (Asma)	Breast Cancer (Cáncer de mama (seno))	Cancer (Cáncer)	Colon Cancer (Cáncer de colon)	Coronary artery (Arteria coronaria)	Diabetes (Diabetes)	Glaucoma (Glaucoma)	High Cholesterol (Hiperlipidemia)	High Blood Pressure (Alta presión arterial)	Kidney disease (Enfermedad del riñon)	Macular degeneration (degeneración macular)	Mental Illness (Enfermedad mental)	Prostate Cancer (Cáncer de prostate)	Rheum arthritis (Artritis reumaloidea)	Stroke (Derrame cerebral)	Thyroid disease (Enfermedad de la tiroides)
Maternal Grandfather (Abuelo Materno)																		
Paternal Grandmother (Abuela Paterna)																		
Paternal Grandfather (Abuelo Paterno)																		
Additional Relatives (Parientes Adicionales):																		

Adopted (Adoptado/a) ☐

SOCIAL HISTORY (HISTORIA SOCIAL)

Tobacco Use (Uso del Tabaco): ☐ **Yes** (Sí) ☐ **No** **Packs per day** (Paquetes por día): ☐ .25 ☐ .5 ☐ 1 ☐ 1.5 ☐ 2 ☐ ____

Years of use (Años de uso): ☐ .5 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ ___ **Quit date** (mm/dd/yyyy) (Fecha de cuando dejó de usarlo - mm/dd/año):

Smokeless Tobacco (Tabaco sin humo/de mascar): ☐ **Yes** (Sí) ☐ **No** **Quit date** (mm/dd/yyyy) (Fecha de cuando dejó de usarlo - mm/dd/año):

Ready to Quit (Listo para dejar de usar el tabaco) ☐ **Yes** (Sí) ☐ **No**

Comment (comentario):

Alcohol Use (Uso de Alcohol): ☐ **Yes** (Sí) ☐ **No** **Comment** (comentario):

Drinks/Week: (Bebidas/Semana)
_____ **glasses of wine** (copas de vino)
_____ **cans of beer** (latas/botes de cerveza)
_____ **shots of liquor** (tragos de licor)
_____ **drinks containing 0.5 oz of alcohol** (bebidas con un contenido de 0.5 onzas de alcohol)

Alcohol/Week (Alcohol/Semana):

Drug Use (Uso de Drogas): ☐ **Yes** (Sí) ☐ **No** **Comment:** (Comentario)

Use/Week: _____ (Uso/Semana)

Types: (Tipo)
☐ **Amphetamines** (Anfetaminas) ☐ **Cocaine** (Cocaína)
☐ **Barbituates** (Barbitúricos) ☐ **Marijuana**
☐ **Benzodiazepines** (Benzodiazepinas) ☐ **Other** (Otra) _____

Sexual Activity (Actividad Sexual): ☐ **Yes** (Sí) ☐ **No** ☐ **Not Currently** (No Actualmente) **Comment** (comentario):

Partners (Compañero/a (s); Pareja): ☐ **Male** (Hombre) ☐ **Female** (Mujer)

Birth Control / Protection: (Método Anticonceptivo/Protección)
☐ **Abstinence** (Abstinencia) ☐ **Coitus interruptus** (Coito interrumpido) ☐ **Condom** (Condón) ☐ **Diaphragm** (Diafragma)
☐ **Implant** (Implante) ☐ **Injection** (Inyección) ☐ **Inserts** (Cápsulas anticonceptivas vaginales) ☐ **IUD** (dispositivo intrauterino) ☐ **OCP** (Píldora anticonceptiva oral)
☐ **Patch** (Parche) ☐ **Post-menopausal** (posmenopausea) ☐ **Rhythm** (Ritmo) ☐ **Spermicide** (un espermicida) ☐ **Sponge** (Esponja)
☐ **Surgical** (cirugia) ☐ **Other** (otro) ☐ **None** (nada)

Diet (Dieta/Régimen):
☐ **Regular low-fat** (Normal - bajo en grasa) ☐ **Low carb** (Baja en carbohidratos) ☐ **Gluten free** (Sin gluten)
☐ **Vegan** (Vegetariano estricto) ☐ **Atkins** ☐ **Zone**
☐ **Vegetarian** (Vegetariano) ☐ **High protein** (Rica en proteínas) ☐ **Master cleanse**

Exercise (Ejercicio):
☐ **Walking:** _____ /wk (semana) (Caminando) ☐ **Yoga:** _____ /wk (semana)
☐ **Running:** _____ /wk (semana) (Corriendo) ☐ **Weights:** _____ /wk (semana) (Levantando pesas)
☐ **Swimming:** _____ /wk (semana) (Nadando) ☐ **Cycling:** _____ /wk (semana) (Bicicleta)

FAMILY MEDICAL CENTER of Georgetown

My Medication List

This list could save MY life!

Name: _____ Date: _____ Physician: _____ Phone: _____

Address: _____ Physician: _____ Phone: _____

City: _____ State: _____ Zip: _____ Birthdate: _____ Physician: _____ Phone: _____

Emergency Contact: _____ Pharmacy: _____ Phone: _____

Relationship: _____ Phone: _____ Pharmacy: _____ Phone: _____

Medical History: _____

Drug Allergies: _____

Medication	Strength	How often?	Comments

Medication	Strength	How often?	Comments

***REMEMBER TO UPDATE YOUR MEDICATIONS – Mark out medications that are discontinued. Add new medications started.**