

**PLEASE GIVE THIS COMPLETED FORM TO THE NURSE
AFTER YOU ARE CALLED BACK**

PATIENT NAME: _____

***CURRENT PROBLEMS** NO PROBLEMS TODAY - ROUTINE VISIT

REASON FOR YOUR VISIT TODAY	INDICATE AFFECTED SIDE (IF APPLICABLE)	STATUS (NEW OR ONGOING PROBLEM)	DATE OF ONSET

***SURGICAL HISTORY** NO HISTORY OF SURGERIES

TYPE OF PROCEDURE	PROCEDURE DATE

***MEDICATIONS** NO MEDICATIONS TAKEN

NAME OF MEDICATION	DOSE

PHARMACY OF CHOICE: _____

***VACCINATIONS** NO HISTORY OF VACCINATIONS

TYPE	DATE GIVEN	CLINIC/FACILITY WHERE ADMINISTERED

***ALLERGIES** NO KNOWN ALLERGIES

ALLERGIC TO/ALLERGEN	TYPE OF REACTION	SEVERITY (MILD,MODERATE,SEVERE)	DATE OF ONSET

***SOCIAL HISTORY (CIRCLE ALL THAT APPLY)**

(CIRCLE SMOKING STATUS): NEVER SMOKED - FORMER SMOKER - CURRENT EVERY DAY SMOKER - CURRENT SOME DAY SMOKER - UNKNOWN OTHER TOBACCO USE: YES/NO
 SMOKED OR TOBACCO USE SINCE AGE: _____ YEARS OF USE: _____ ALCOHOL USE: YES/NO HOW OFTEN DO YOU USE ALCOHOL: EVERY DAY/SOCIALLY
 DIET: _____ CAFFEINE USE: YES/NO ADVANCE DIRECTIVE: YES/NO CURRENTLY PREGNANT: YES/NO
 CHANGES IN FAMILY OR SOCIAL SITUATION: YES/NO LEGALLY BLIND: YES/NO HARD OF HEARING OR DEAF: YES/NO SEAT BELT OR CAR SEAT USED ROUTINELY: YES/NO
 MOSQUITO REPELLENT USED ROUTINELY: YES/NO SUNSCREEN USED ROUTINELY: YES/NO SMOKE DETECTORS IN HOME: YES/NO
 NUMBER OF SIBLINGS: _____ POOL EXPOSURE (FOR CHILDREN): YES/NO SPORTING ACTIVITIES: _____

USE BACK OF FORM FOR MORE COMMENTS IF NEEDED

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***PAST MEDICAL HISTORY (CIRCLE ALL THAT APPLY)**

NO TO ALL

ADD/ADHD
 ABNORMAL PAP
 ABUSE/DOMESTIC VIOLENCE
 ACID REFLUX (GERD)
 ACNE
 ALLERGIES
 ANEMIA
 ANESTHESIA COMPLICATIONS
 ANXIETY DISORDER
 ARTHRITIS
 ASTHMA
 AUTISM SPECTRUM DISORDER
 AUTOIMMUNE DISORDER
 BEDWETTING
 BIRTH DEFECTS/INHERITED DISEASE
 BLADDER PROBLEMS
 BLOOD DISEASES
 BLOOD TRANSFUSIONS
 BREAST CANCER
 BREAST PROBLEM
 COPD
 CANCER
 CHICKEN POX
 CONGENITAL ANOMALIES
 CONSTIPATION
 CORONARY ARTERY DISEASE

DEPRESSION
 DEVELOPMENTAL DISORDERS
 DIABETES
 DIVERTICULITIS
 EAR OR HEARING PROBLEMS
 EATING DISORDER
 ECZEMA
 ENDOMETRIOSIS
 FIBROMYALGIA
 GI PROBLEMS
 GYN PROBLEMS
 GOUT
 HIV
 HEAD INJURY/CONCUSSION
 HEADACHES/MIGRAINES
 HEART DISEASE
 HEART PROBLEMS/MURMUR
 HEPATITIS
 HIGH BLOOD PRESSURE
 HIGH CHOLESTEROL
 HOSPITAL ADMISSION
 HYPERTHYROIDISM
 INFERTILITY
 KIDNEY DISEASE/KIDNEY STONES
 LIVER DISEASE
 LUNG DISEASE

MENTAL ILLNESS
 MUSCLE PROBLEMS
 JOINT/BONE PROBLEMS
 NEUROLOGICAL DISORDER
 OSTEOPOROSIS
 OVARIAN CANCER
 PHLEBITIS
 POLYPS
 PRE-ECLAMPSIA
 PSYCHIATRIC ILLNESS
 PULMONARY EMBOLISM
 STD
 SEIZURES/EPILEPSY
 SKIN PROBLEMS
 STROKE
 THROMBOPHILIAS
 THYROID PROBLEMS
 TUBERCULOSIS
 VARICOSITIES (VARICOSE VEINS)
 VISION OR EYE PROBLEMS

IF OTHER AND NOT LISTED, PLEASE WRITE BELOW:

***FAMILY HISTORY**

UNKNOWN

RELATION	PROBLEM	ONSET AGE	DIED AT AGE

***PRENATAL AND BIRTH HISTORIES (IF APPLICABLE)**

NUMBER OF PREGNANCIES _____ NUMBER OF LIVE BIRTHS _____

PROBLEM	DATE

***OTHER PHYSICIANS OR SPECIALISTS YOU ARE CURRENTLY UNDER THE CARE OF**

NAME	SPECIALITY	PHONE

Patient Registration

Patient Information			
Last Name	First Name	Middle Initial	
Mailing Address		City, State	Zip
Physical Address		City, State	Zip
Home Phone Number	Social Security Number	Date of Birth	Age
Cell Phone Number	E-Mail	Marital Status:	
In Case of an Emergency		Phone Number	Relationship to Patient
How did you hear about our office?		Referring Physician (if applicable)	
Is this: [] Injury [] or Illness	Work Related? [] Yes [] No	Auto Accident Related? [] Yes [] No	Other Accident Related? [] Yes [] No
Do you have an Advance Directive or Living Will? [] Yes [] No		Sex : [] Male [] Female	
Responsible Party Name:		Responsible Party Date of Birth:	
Pharmacy Name	Address	Phone Number	
Insurance Coverage # 1			
Insurance Company Name	Employer's Name	Employer's Phone Number	
ID Number	Group Number	Insurance Company Phone Number	
Policy Holder Name	Relationship to Policy Holder: [] Self [] Spouse [] Child		
Policyholder Date of Birth:	Policyholder SSN:		
Insurance Address	City	State	Zip

Patient Registration

Insurance Coverage # 2			
Insurance Company Name	Employer's Name	Employer's Phone Number	
ID Number	Group Number	Insurance Company Phone Number	
Policy Holder Name	Relationship to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child		
Insurance Address	City	State	Zip

ASSIGNMENT AND RELEASE: I hereby assign my insurance benefits to be paid directly to the physician. I also authorize the physician to release all information contained in my financial and medical records to my insurance company or health plan, or any other person or entity that is responsible for paying or processing for payment any portion of my bill. I understand that I am totally responsible for payment of all fees and services rendered. I permit a copy of this authorization to use in place of the original.

MEDICARE BENEFICIARY ASSIGNMENT AND RELEASE: I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by Yoakum Family Practice. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

NO SHOW POLICY: After three no-shows to your appointment you are subject to be terminated as a patient of Yoakum Family Practice. Please notify us 24 hours in advance if you need to cancel or reschedule your appointment.

FINANCIAL OBLIGATION: I hereby acknowledge that I understand there may be services provided that will not be covered by my insurance carrier, and fully understand that I am totally fully responsible for payment of all fees and services rendered, regardless of insurance coverage or other responsibilities and ultimately responsible for payment in full if my insurance company does not pay in a timely manner.

CONSENT FOR TREATMENT: I hereby authorize the physician, nurses, medical assistants and staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: By signing below, you indicate that Yoakum Family Practice has provided this Notice of Privacy Practices to you.

I have read each of the statements above and authorize, understand and agree to each statement.

Patient's Signature	Date:
Patient Name (please print):	



NOTICE REGARDING YOUR LAB WORK

It has come to our attention that several insurance companies are denying Lab Tests that are drawn in our office and sent to an outside lab. It may be to your best interest to contact your insurance company before having your lab drawn. You will be responsible for charges that are denied by your insurance company.

Patient's Printed Name

Date

Signature of Patient or Responsible Party

FINANCIAL POLICY

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept all major credit cards.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment.
- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of service.
- In the event that your health plan (Medicare/Medicaid/Commercial insurance) determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.
- Prior arrangements will need to be made with our office for all worker's compensation claims. We only file claims for specific providers within our practice and only to insurance companies with whom we are in-network with.
- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

Patient's Printed Name

Date

Signature of Patient or Responsible Party

PATIENT RECORD OF DISCLOSURES

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 is 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 (check all that apply):

Home Telephone _____

- Leave message with detailed information
- Leave message with call-back number only

Written Communication:

- Mail to my home address
- Mail to my work/office address
- Fax to this number _____

Work Telephone _____

- Leave message with detailed information
- Leave message with call-back number only

RELEASE OF HEALTH INFORMATION AND/OR RECORDS

I authorize the release of my health information and/or records. This information may be released to the following individual(s):

Name: _____

Relationship: _____

Phone Number: _____

Name: _____

Relationship: _____

Phone Number: _____

This ***Release of Health Information and/or Records*** will remain in effect until terminated by me in writing.

My health information and/or records are not to be released to anyone.

Patient's Printed Name

Date

Signature of Patient or Responsible Party

Birthdate



CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribe Program

ePrescribing is way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor’s office to the pharmacy. The ePrescribe Program also includes:

Formulary and benefit transactions - Gives the health care provider information about which drugs are covered by your drug benefit plan.

Fill status notification - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.

Medication history transactions - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

The medication history information would include medications prescribed by your health care provider at Yoakum Family Practice as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS.

As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.

Consent

- 1. Prescription refill policy – It is the policy of Yoakum Family Practice that medication refills will be processed within two business days (no weekends or holidays) of receipt of the request.
- 2. By signing this consent form you are agreeing that your provider at Yoakum Family Practice may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.
- 3. You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.
- 4. This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Yoakum Family Practice to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patient’s Printed Name

Date

Signature of Patient or Responsible Party

Birthdate



PATIENT PORTAL TERMS AND CONDITIONS AGREEMENT

Yoakum Family Practice provides a patient portal through a third party vendor for the exclusive use of its patients. The patient portal is designed to enhance the ability of our patients to view a limited portion of their confidential patient information. All users must be established through registration as a Yoakum Family Practice patient. The patient portal is provided as a courtesy to our patients. However, if abuse or negligent usage of patient portal persists, we reserve the right at our own discretion to terminate patient portal offering, suspend user access, or modify services offered through the patient portal.

Guidelines and Security

Yoakum Family Practice offers secure viewing of limited health information to our patients who wish to view parts of their records online. The patient portal is provided through a third party vendor on a HIPAA compliant VPN with encryption that meets HIPAA standards. While we believe that the IT infrastructure and data are safe and secure, it does not guarantee unforeseen adverse events cannot occur. All new and established patients have signed and have been offered a copy of our HIPAA Notice of Privacy Practice. If you do not recall having signed the HIPAA Notice of Privacy or need to reacquaint with our policy, a copy can be provided to you for your review. This patient portal is a valuable tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. By providing Yoakum Family Practice with your e-mail address you accept the risks and agree to the conditions of participation. Once your email is provided and the Patient Portal Terms and Conditions Agreement is signed you will receive an email notification that instructs you how to log in for the first time. Please keep this email in a safe place for future reference. Following the instructions on the email, you should be able to log in using the link received in the initial email.

Registration

You agree that the information that you provide upon registration to use the Patient Portal and at all other times will be true, accurate, current, and complete. You also agree that you will ensure that this information is kept accurate and up to date at all times. In particular, you must keep your e-mail address up to date. If you change your mind and wish to opt out of the Portal, you must contact us at Yoakum Family Practice. We are unable to opt out of the Portal over the phone.

User ID and Password

When you register, you will be asked to provide a password. Since you will be responsible for all of the activities that occur with respect to your User Account, we ask that you keep your password confidential. Your Account is solely for your personal use, and you shall not authorize others to use your User Account, including your profile or email address. You must notify us of any unauthorized use of your password or if you believe that your password is no longer confidential.

Emergency-related Questions via the Patient Portal

The Patient Portal is not to be used for emergency related health care issues. Please call Yoakum Family Practice directly with any question that you would like answered within 24 hours. If you are experiencing a health care emergency, call 911 or visit the nearest emergency room.

PATIENT PORTAL TERMS AND CONDITIONS AGREEMENT (CONTINUED)

Patient Portal Limitation of Liability

To the fullest extent allowed by law, in no event shall Yoakum Family Practice (or any of its officers, directors, shareholders, employees, agents, representatives, successors and assigns) have any liability to you for any indirect, special, incidental, exemplary, punitive or consequential damages whether arising in contract, equity, negligence, intended conduct, or otherwise (including breach of warranty, negligence, gross negligence, willful misconduct, and strict liability in tort), including, without limitation, damages arising from delay, loss of goodwill, loss of or damage to data, lost profits, revenue or savings (actual or anticipated), or other economic loss or lost profits in connection with or ensuing from (I) the use or inability to use the patient portal, (II) any transactions conducted through or facilitated by the patient portal, including any offers or incentives realized by you through your use of the patient portal; (III) any claim attributable to errors, omissions, or other inaccuracies in the patient portal, (IV) any unauthorized access to or alteration of your transmissions or data, or (V) any other matter related to the patient portal or any content or information provided on the patient portal, even if one has been advised of the possibility of such damages.

I have read and fully understand this consent. I understand the risks associated with online communications. By checking "I accept" below I intend to sign this consent, I hereby give my informed consent to participate in the patient portal, and I hereby agree to and accept all of the provisions contained above. A copy of this agreement will be included in my medical record.

Indicate your acceptance to be bound by the terms of this agreement by checking "I Accept" below and following the other instructions in the registration process.

If you choose not to become a member of the portal check "I Do Not Accept"

- I Accept - Patient email address: _____
- I Do Not Accept or Choose to Opt Out

Signature of Patient/Parent/Conservator/Guardian

Date/Time

Printed Name

Authority/Relationship to Patient

Witness

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code 32.003).

Signature of Minor

Date



1200 Carl Ramert Drive, Suite D
Yoakum, TX 77995
P: 361.293.7061
F: 361.293.6559

CONSENT TO RELEASE MEDICAL INFORMATION

1. I hereby authorize:

Previous provider name and/or clinic name: _____

Previous provider address: _____

Previous provider phone number: _____

To release the following health care records of:

Patient name: _____

Patient address: _____

Patient SSN: _____ Patient DOB: _____

2. Information to be released:

Copy of complete medical records

Including information related to HIV testing and/or results

History and physical

Other: _____

3. Information to be released to: _____

4. Purpose of disclosure: _____

5. Specification of the date, event or condition upon which the consent expires: _____

I understand this consent can be REVOKED at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. The facility, its employees, officers, and providers are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Patient/Guardian Signature

Date

Relationship to Patient

Witness

Date



WELCOME TO OUR PRACTICE

Date: _____

Name: _____

Address: _____

City/Zip: _____

Appointment Date & Time: _____

We are pleased that you have chosen us for all your healthcare needs. Attached you will find the required paperwork for your appointment. Please complete all the paperwork and return it at your appointment time, for this will reduce waiting time. There is also a check list in this packet for more information that is also needed.

Please bring the following with you to your appointment:

1. All paperwork completed
2. All medication presently taking
3. Driver's license
4. Insurance cards (medicare/medicaid/commercial)
5. Immunization record for children (shot record)
6. Payment for your services (private pay/co-pay/deductible)

Thank you in advance!

Yoakum Family Practice