## Patient Registration - Please review and update the information below to the best of your ability.

**CURRENT PATIENT INFORMATION -- PLEASE PRINT**

Last Name:
First Name:
Middle Name:
Address:
City: State:
Zip:
Home Phone:
Work Phone:
Mobile Phone:
Sex:
Date of Birth:
Social Security No.:_____
Patient Email:
Patient Marital Status:
Patient Language:
Patient Race:
Patient Ethnicity:
Primary Department:
Old Record #: _____

**Guarantor Information (to whom statements are sent)**

Name:
Address:

Relationship to patient: _____
Date of Birth:
Guarantor Social Security No.: _____
Phone: ( ) _____ - _____

**Emergency Contact Information**

Name:
Relationship:
Phone:
Mobile Phone: ( ) _____ - _____

**Primary Pharmacy Information**

Pharmacy Name:_____
Pharmacy Address:_____
_____

**HIPAA Authorization Release**

Name:_____
Relationship:_____

**Primary Insurance Information**

Insurance Plan:
ID:
Policy Holder**:**
Policy Holder Date of Birth: Sex (please circle): **M** or **F**
Patient's relationship to policy holder:
Employer Name:

**Secondary Insurance Information**

Insurance Plan:
Policy Holder Date of Birth: Sex (please circle): **M** or **F**
Patient's relationship to policy holder:
Patient's Co-Pay:
Employer Name:

**ASSIGNMENT AND RELEASE:**

- **I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan. I authorize my provider to release any medical information required to process this claim. I authorize my provider's office to contact me by telephone to remind me of my appointments. I authorize my provider's office to obtain my medication history. A fee for no shows will apply.**

**Signed**_____ **Date:** _____

YOUR FAMILY MEDICAL HOME

PATIENT CONTRACT

Welcome to Your Family Medical Home! We appreciate the opportunity to care for you and your family. The following is provided for your benefit. Please read and sign below.

**Registration:** All patients must complete and sign our Patient Registration form prior to seeing the doctor.

**Hours of operation:** We are available 8:00AM-12:00PM and 1:00PM-5:00PM Monday through Friday. For after hour **emergencies,** an on-call physician is available through our answering service.

**Hospital:** The physicians admit their patients to CHRISTUS Santa Rosa Westover Hills for inpatient care. If you need emergency care, please go to CHRISTUS Santa Rosa Westover Hills Emergency Department or the nearest Texas Med Clinic for evaluation, if possible.

**Appointment time:** Out of respect for your schedule, we strive to stay on time with our appointments. We ask that you arrive 10-15 minutes early for your appointment. Arriving 15 minutes after your scheduled appointment time will be considered a "No Show" and you will be rescheduled. We may call in advance to confirm your appointment. THIS IS ONLY AS A COURTESY AND NOT A REQUIREMENT.

**Cancellations and No Shows:** We require at least 24 hours advance notice when cancelling or rescheduling your appointment. If you do not give 24 hour notice, this may be considered a "No Show" or missed appointment. After three missed appointments we may decide to terminate care. You will be charged **$25.00** for the first "No Show" and **$50.00** for each subsequent "No Show" for routine visits. A Comprehensive Visit or Physical requires a 48 hour advance notice, and a "No Show" is **$50.00.**

**Refills:** We request you contact your pharmacy first, and they will call/fax us with the necessary information to refill your medicine. No refills will be done after hours or on weekends except in cases of a medical emergency (defined as a threat to life, limb or eyesight). Please allow one week to process refill requests and to allow for insurance prior authorizations or other issues regarding your medications.

**Payments:** All applicable fees, deductibles, coinsurance or copays must be paid at the time of your service. This office will verify your benefits to the best of our ability once you supply the correct insurance information. Verification of coverage does not mean that all services rendered will be covered during your visit, however, and uncovered services may be your responsibility to pay. Outstanding balances must be paid prior to further appointments.

**Returned Checks:** A $35.00 fee will be charged by our office for a bad check and the bad check is submitted to the District Attorney's Check Section.

**Transfer of Records:** If you request the transfer of records to another office, there will be a fee for copy/delivery costs. Payment must accompany the request.

**Forms filled by Doctor:** Work or insurance related forms (such as FMLA) may be filled by the doctor. There is a fee for each form that must be paid in advance. Please allow sufficient time for the request to be completed.

**Noncompliance:** Your total health is the result of a committed partnership between you and your physician. We reserve the right to discontinue this relationship for noncompliance with health plan or any of the above policies.

_____ **Out of Network Benefits:** Please be advised that the clinic does not have a contractual agreement with your insurance; therefore this visit will fall under your out of network benefit. This will mean you will have a greater out of pocket expense. This serves as acknowledgment and consent to treat.

_____ **Balances** are due and payable upon first statement. If no payment is made within 90 days, your account will be sent to an outside collection agency for Phase I collections. This will result in an additional fee of $10.00 for each balance transferred. If further collection proceedings are required, past due balances will be turned over to a collection agency, Phase II, without further notice and you may be discharged from the practice as a patient.

Patient Signature

Date

CONSENT FOR TREATMENT

1. I consent to any treatment, test or procedure ordered by and given under the supervision of a physician. (Surgical procedures and anesthesia require additional consent to be signed.)

2. I acknowledge that no guarantees have been made as to the results of the hospital care and medical treatment hereby authorized. I also recognize that all physicians on the staff of the hospital, including the attending physician, are not employees or agents of the hospital.

3. I understand that I am fully responsible for all articles (money, radios, jewelry, dentures, eyeglasses, etc.) and clothing which I retain in my possession (in my room) and for any other articles and/or clothing which may be brought to me while I am a patient at Your Family Medical Home. I understand that Your Family Medical Home and its associates are not responsible for loss or damage to any property which is not turned in for safekeeping.

4. Texas law permits the disclosure of patient health care information without authorization in certain specific settings, including disclosure for payment purposes, for continuing care and to an organ procurement organization

5. I acknowledge that I have been given a copy of the "Patient Rights and Responsibilities" for my personal use.

6. I acknowledge that I have been given a copy of Your Family Medical Home "Notice of Privacy Practices" for my personal use.

7. I acknowledge that I may request the form for Advance Directives from the nursing staff and/or physician at any time.

8. The physician's office has my consent to leave telephone messages at my home or as otherwise instructed.

9. I acknowledge Your Family Medical Home uses e-prescribing to facilitate medication management for the patient and the patient's medication history will be uploaded through a RX HUB. I also understand that immunization history will be transferred to and from the San Antonio Immunization Registry System via interface

**NOTE: This statement is to be signed by ALL patients on a yearly basis at the time of registration. When the patient is a minor, parent or legal guardian must sign the statement.

WITNESS_____ SIGNED_____

DATE_____Time_____

## PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

1 /We have received a copy of your Notice of Privacy Practices. I /We understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I /We may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

For Sole / Individual Patient Account:

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

Acct # _____

For Family Account:
Below, is a list of the dependents (under 21 years of age), on my/our account. As the parent / guardian, I acknowledge on their behalf.

| Patient Name | Date of Birth | Relationship | Acct # |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Parent / Guardian : _____ DOB: _____

Signature: _____ Date: _____

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## OFFICE USE ONLY

Best effort was made to obtain the patient's signature on this Notice of Privacy Practices Acknowldegement. Patient refused, as documented below:

| Reason: | |
|---|---|
| Date: | Employee Witness: |
| Date Entry: | |

**Patient Name: _____**

**Date: _____**

# FAMILY MEDICAL HOME HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your healthcare provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

## ALLERGIES

List ***anything*** that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

| ALLERGY | REACTION |
|---|---|
| 1. _____ | _____ |
| 2. _____ | _____ |

## LIST ALL MEDICATIONS TAKEN

**□ NO meds taken**

Medication (in mg) and how many times per day

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

## IMMUNIZATION HISTORY

Circle all vaccinations you have received and list the date you last received them if known

**□ NONE received in the past 10 years**

| | | | |
|---|---|---|---|
| Chicken pox | Date: _____ | Meningococcus | Date: _____ |
| Tetanus | Date: _____ | Tdap | Date: _____ |
| Flu | Date: _____ | Pneumonia | Date: _____ |
| Measles, Mumps, Rubella | Date: _____ | | |

## PERSONAL ILLNESS:

Please check all diseases/conditions that apply to you.

**□ NO Medical Illnesses**

__ Abnormal pap smear
__ Asthma / Breathing difficulties
__ ADHD
__Anxiety / Depression
__ Allergies
__ Bleeding Disorder
__ Cancer / type _____
__ Diabetes
__ Fibromyalgia
__ Gum disease
__ Headaches / Migraines
__ Kidney Disease
__ Liver Disease / Gallbladder problems
__ Mental illness
__ Heart disease / Heart attack
__ Heart palpitations / Irregular heartbeat
__ Heart murmur
__ Heartburn / Reflux
__ Hernia or back problems
__ High Blood Pressure
__ High Cholesterol
__ Osteoporosis
__ Seizures
__ Sleep Apnea
__ Stroke / CVA
__ Thyroid Disease
__ Other: _____

## SURGICAL HISTORY

□ **NO surgeries**

| **Type:** | **Reason** | **Year** | **Hospital** |
|---|---|---|---|
| **1.** | | | |
| **2.** | | | |
| **3.** | | | |

## FAMILY HISTORY:

HAVE ANY FAMILY MEMBER EVER HAD ANY OF THE FOLLOWING? **PLEASE INDICATE WHICH ONE**

**M=MOTHER F=FATHER B=BROTHER S=SISTER GF=GRANDFATHER GM=GRADMOTHER**

□ **NO Major medical illnesses in family**

__ Abnormal pap smear
__ Asthma / Breathing difficulties
__Anxiety / Depression
__ Allergies
__ Bleeding Disorder
__ Cancer / type _____
__ Diabetes
__ Fibromyalgia
__ Headaches / Migraines
__ Osteoporosis
__ Kidney Disease
__ Mental Illness
__ Heart disease / Heart attack
__ Heart palpitations / Irregular heartbeat
__ Heartburn / Reflux
__ Hernia or back problems
__ High Blood Pressure
__ High Cholesterol
__ Liver Disease / Gallbladder problems
__ Seizures
__ Stroke / CVA
__ Thyroid Disease
__ Other: _____

## SOCIAL HISTORY

Do you Smoke? _____ How much? _____ How many years? _____
Did you smoke in the past? _____ How many years? _____
Do you drink Alcohol? _____ How much? _____ How many years? _____
Recreational Drugs? _____ Which? _____
What is your primary language? _____
What is your job? _____
What is your religion? _____
Has there been any physical, sexual or emotional abuse? YES / NO
Highest educational level achieved: GRADE / COLLEGE / POST-COLLEGE

## PLEASE CHECK ALL SYMPTOMS EXPERIENCED WITHIN THE LAST MONTH

□ **I have NO other symptoms**

**Allergy**
__ Frequent sneezing
__ Hives
__ Itching
__ Sinus Pain/Pressure
__ Skin rash
__ Nasal congestion

**Respiratory**
__ Cough
__ Wheezing
__ Snoring

**Endocrine**
__ Increased thirst/Hunger/Urination
__ Hair loss

**Musculoskeletal**
__ Back pain
__ Joint pains
__ Joint swelling
__ Muscle pain

**Heart**
__ Arm pain with exercise
__ Chest pain with exercise
__ Short of breath lying down
__ Swelling in legs
__ Heart racing

**Gastrointestinal**
__ Stomach pain
__ Black/Tarry stools
__ Frequent heartburn
__ Trouble swallowing
__ Vomiting
__ Diarrhea
__ Constipation

**Neurologic**
__ Fainting
__ Headaches
__ Memory Loss
__ Weakness
__ Dizziness
__ Numbness

**General**
__ Tiredness
__ Fevers
__ Weight Loss/ Weight Gain
__ Vision problem
__ Hearing loss

**Genitourinary**
__ Trouble urinating
__ Frequent urination
__ Loss of urine control
__ Blood in urine
__ Heavy vaginal bleeding
__ Irregular/Missed periods
__ Sexual problem

**Psychiatric**
__ Anxiety / Stress
__ Mood Swings
__ Depressed mood
__ Alcohol Overuse
__ Confusion

# FAMILY MEDICAL HOME, PLLC

9179 Grissom Rd, Suite 101
San Antonio, TX 78251
P: (210) 680-8081

Jesus Rodriguez, MD
Jesus Yanes III, MD
Alessandro Valverde, MD
Horacio Ramirez, MD

9410 Dugas Dr., Suite 104
San Antonio, TX 78245
P: (210) 680-8081

Marcy Youngdahl, MD
Sheila Pinkston, MD

## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
**(An Incomplete Form will not be accepted)**

Patient Name: _____

DOB: _____ SS#: _____ Phone: _____

Address _____

| PATIENT MUST PROVIDE COMPLETE INFORMATION IN ORDER TO PROCESS | |
|---|---|
| **Records From:** (Name & Address)<br>_____<br>_____<br>Fax: _____ | **Records To:** (Name & Address)<br>_____<br>_____<br>Fax: _____ |

Please send a copy of my records as indicated for date(s) of Treatment: _____
__ Office Visits __ Lab Reports __ H&P __ X-ray Reports
__ Discharge Summaries __ Immunization History __ Other __ All Records

Purpose for releasing medical information _____
I will do what I can to assist in the expeditious transmission of this request.

Signature of Patient, Parent/Guardian _____
Witness _____ Date _____

I understand that my express consent is required to release any health information relating to testing, diagnosis and/or treatment of alcohol or drug related medical problems, and this special consent also will apply to HIV/AIDS related diagnoses, sexually transmitted diseases and psychiatric disorders/mental health. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 C.F.R. Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. This authorization can be revoked but not retroactive to the release of information made in good faith.

Signature of Patient: _____
Signature of Parent/Guardian: _____
Witness_____ Date: _____

Permission to FAX records for urgent care or medical emergency? __ Yes __ No