PrimeCare Family Practice
1001 N. Waldrop Dr., Ste. 801
Arlington TX, 76012
817-962-0056 Phone
817-962-0057 Fax

PATIENT INFORMATION

How did you hear about us? _____

Legal Last Name: _____Legal First Name: _____ MI: _____

Preferred Name: _____ DOB: ___/____/____ SSN: _____-_____-_____

Home Address: _____ City: _____ Zip: _____

Preferred Number Phone: _____ Cell/Work/Home

Preferred Pharmacy: _____ Address: _____

Marital Status: Single / Married / Partnered / Separated / Divorced / Widowed / Other: _____

Name of your spouse/partner (if applicable): _____

What sex were you assigned at birth? Male / Female / Other: _____

What is your current gender identity? Male / Female / Non-Binary / Other: _____

What pronouns do you prefer that we use when talking to you? She, Her / He, Him / They, Them

Race: Black or African American / American Indian / White / Hispanic or Latino / Asian /

Other: _____

Primary Language: English / Spanish / other: _____

Previous Primary Care Physician: _____

Current Insurance Information

Primary Insurance: _____ Member ID Number: _____

Policyholder's Name: _____ Policyholder's Phone: _____

Policyholder's DOB: _____ Relationship to Patient: _____

Secondary Insurance: _____ Member ID Number: _____

Policyholder's Name: _____ Policyholder's Phone: _____

Policyholder's DOB: _____ Relationship to Patient: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Advance Directives

Does someone have Medical Power of Attorney giving them the power to make decisions about your care when you are no longer capable of making them yourself? Yes / No

If yes, what is the name of this person? _____

What is their relationship to you? _____

What is the best phone number to contact them at? _____

Do you have a Directive to Physicians and Family or Surrogates (also known as a Living Will)? Yes / No

Do you have an Out of Hospital Do Not Resuscitate Order (DNR)? Yes / No

Patient Portal Account

A portal account will be created for you at your first visit. This is the primary method of communication with the office staff regarding lab results, prescription refill request, and basic questions regarding your health. You may also request future appointments on the web portal and review medical summaries. You may also receive automated text and voice messages at the number listed above. **You may only have one patient portal account associated with each email address, so if the email address listed below belongs to someone who is also our patient, IT WILL NOT WORK! You must use a unique email address for each patient.**

Email: _____ @ gmail.com yahoo.com other: _____

I hereby authorize the insurance carrier listed above to make payments directly to PrimeCare Family Practice, LLC and understand that I am financially responsible for all changes incurred that are not covered in full by my insurance. I further understand that if I enroll in another insurance plan, it is my responsibility to notify PrimeCare Family Practice, LLC; otherwise I will be responsible for payment of services rendered.

_____ _____

Signature Date

_____

Printed Name

The parties agree that this agreement may be electronically signed. The parties agree that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

PATIENT INFORMATION

Name: _____ DOB: _____ Date: _____

Drug Allergies and Reactions:_____

_____

Please list ALL medications you take, including maintenance, over the counter (OTC) medications, and herbal supplements. Include specific doses and when taken. If you do not know, please call your pharmacist to confirm.

(example: Lisinopril 20mg)	(example: one tab)	(example: daily)

Patient's Personal Medical History: (please circle all that apply)

ADHD	Bipolar Disorder	Diabetes Type 1 / 2	Hernia	Macular Degeneration	Pulmonary Embolism
Alcoholism	Bladder Problems / Incontinence	Diverticulitis	High Blood Pressure	Neuropathy	Rheumatoid Arthritis
Allergies, seasonal	Bleeding Problems:	DVT (blood clot)	Kidney Disease	Osteoarthritis	Seizure Disorder/ Epilepsy
Alzheimer's Disease	Cancer:	GERD	High Cholesterol	Osteopenia/ Osteoporosis	Sleep Apnea
Anemia	Chronic Headaches / Migraines	Glaucoma	HIV	Parkinson's Disease	Stomach Ulcer
Anxiety	COPD/Emphysema	Heart Attack	Hepatitis A / B / C	Peripheral Vascular Disease	Stroke
Arrhythmia	Depression	Heart Disease	Liver Disease	Prostate Problems	Tuberculosis
Asthma	Dementia	Heart Failure	Lupus	PTSD	Thyroid Disorder

Other Medical Problems Not Listed Above:

_____

_____

_____

Preventive Health Care Dates:

Colonoscopy: _____ Normal / Abnormal

Cologuard: _____ Normal / Abnormal

Mammogram: _____Normal / Abnormal

DEXA (bone scan): _____ Normal / Abnormal

Pap Smear: _____ Normal / Abnormal

Vaccine Dates:

Tdap: _____

Shingrix: _____

Seasonal Flu: _____

Pneumovax: _____

Prevnar 13: _____

Surgical History: (Please list all prior surgeries and approximate dates performed)

_____ _____

_____ _____

_____ _____

Social History:

Do you identify as: (check all that apply)

- Straight
- Gay / Lesbian
- Bisexual
- Asexual
- Other: _____

Please describe your sexual activity during the last year (check all that apply):

- Monogamous relationship with (one) man
- Monogamous relationship with (one) woman
- I had multiple male partners
- I had multiple female partners
- I had both male and female partners
- I did not have any sexual partners
- Other: _____

Smoker: (please check)

___ Current

___ Past

___ Never

Packs per day: _____

Number of years: _____

Alcohol: (please check)

___ Social

___ Daily

___ Never

Type: _____

Amount per week: _____

Drugs: (please check)

___ Current

___ Past

___ Never

Type: _____

How often: _____

Have you ever injected any type of substance? Yes / No

Do you feel safe at home? Yes / No

Over the last 2 weeks, how often have you been bothered by the following problems?

1. Little interest or pleasure in doing things? Not at all Several days More than half the days Nearly every day
2. Feeling down, depressed or hopeless? Not at all Several days More than half the days Nearly every day

How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days? _____

On those days that you engage in moderate to strenuous exercise, how many minutes, on average, do you exercise? _____

Occupation: _____ Employer: _____

Family History of Blood Relatives:

Father

Substance Abuse:	Diabetes	High Blood Pressure
Mental Health Issues:	Dementia	High Cholesterol
Cancer:	Heart Disease	Stroke

Other: _____

Mother

Substance Abuse:	Diabetes	High Blood Pressure
Mental Health Issues:	Dementia	High Cholesterol
Cancer:	Heart Disease	Stroke

Other: _____

Siblings

Substance Abuse:	Diabetes	High Blood Pressure
Mental Health Issues:	Dementia	High Cholesterol
Cancer:	Heart Disease	Stroke

Other: _____

_____ _____

Signature Date

_____

Printed Name

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GENERAL PATIENT CONSENT FOR CARE

I, the undersigned, for myself, hereby consent to medical care and treatment, as ordered by a provider, while such medical care and treatment is provided through PrimeCare Family Practice on an outpatient/ office visit basis. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider; including treatment by a mid-level provider (nurse practitioner or physician assistant), and other health care providers or the designees under the direction of a physician, as deemed reasonable and necessary.

I am aware that the practice of medicine is not an e act science and I acknowledge that no guarantees have been made to me as to the result of treatments or e aminations at PrimeCare Family Practice. I understand that I have the right to discuss the treatment plan with my physician about the purpose, potential risks and benefits of any test ordered for me. If I have any concerns regarding any test or treatment recommended by my health care provider, I am encouraged to ask questions.

By signing below, I indicate that (1) I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) I consent to treatment at this office or any other satellite office under common ownership. This consent will remain fully effective until it is revoked in writing. I have the right at any time to discontinue services.

I have requested medical services from PrimeCare Family Practice on my behalf and understand that by making this request, I become fully responsible for any and all charges incurred in the course of treatment authorized. I give permission for PrimeCare Family Practice to give me medical treatment.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Signature Date

_____

Printed Name

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TELEMEDICINE INFORMED CONSENT

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
    a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
    a. I may revoke my right at any time by contacting PrimeCare Family Practice at (817) 962-0056
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing processes.
    a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
    b. I understand that I will be responsible for any out-of-pocket cost such as copayments or coinsurances that apply to my telemedicine visit.
    c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

_____ _____

Signature Date

_____

Printed Name

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PRIVACY POLICY

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights to privacy regarding your protected health information. Protected health information (PHI) may originate in your medical record at PrimeCare Family Practice or maybe received from outside health entities and filed in your medical record. You consent that this information can and will be used by PrimeCare Family Practice in the following ways:

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and conducting, planning, and directing treatment. For example, all aspects of your medical history, examination/diagnostic results, and treatment received with be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from all sources of coverage such as government and private insurance carriers. For example, your insurance carrier may request and receive information on dates of service, services provided, and the medical condition(s) being treated.

Health Care Operations: Your health information may be used as necessary to support day-to-day activities and management of PrimeCare Family Practice and affiliated networking organizations. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Prescription History: By signing this document, you authorize staff members to view your prescription history from external sources.

Law Enforcement: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department. All vaccinations received in this office will be uploaded to ImmTrac (Texas Immunization Registry).

Specimens Obtained: You consent to property transfer of any specimens (tissue obtained during medical testing and/or treatment) to PrimeCare Family Practice.

Appointment Reminders: Your health information may be used by our staff for the purpose of appointment reminders and other pertinent notifications by phone, text message, email, postal mail, or via the online patient portal.

Information about Treatments: Your health information may be used to send you information on the treatment and management of your medical condition(s) that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Disclosures Requiring your Authorization: Disclosures of your health information (medical records, insurance information, individual picture, etc.) or its use for any purpose other than those listed above require specific written authorization. However, your decision to revoke this authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Your Patient Rights

You have certain rights under the federal privacy standards. These include:

1. The right to request restrictions on the use and disclosure of your protected health information.
2. The right to receive confidential communications concerning your medical condition and treatment.
3. The right to inspect and copy your protected health information.
4. The right to request amendments or submit corrections to your protected health information.
5. The right to receive an accounting of how and to whom your protected health information has been disclosed.
6. The right to receive a printed copy of this notice. (This is our printed notice).

Duties of PrimeCare Family Practice

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice at your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

_____ _____

Signature Date

_____

Printed Name

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Authorization to Release Medical Information to Individuals/Family Members

In accordance with federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your healthcare provider or staff of PrimeCare Family Practice to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

I, the Patient, hereby authorize PrimeCare to release my medical information (appointments, lab/x-ray results, diagnoses, treatments, medications, surgeries, clinical condition, etc.) verbally or via postal mail, telephone, fax, or email to the following individuals if requested:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

_____ _____

Signature Date

_____

Printed Name

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FINANCIAL AGREEMENT

This agreement is between PrimeCare Family Practice and the patient. If you may have any questions regarding these policies, please feel free to ask the front desk staff to clarify for you.

Payment Policies:
It is our policy to collect payment when you arrive for you appointment. This includes co-payments, estimated co-insurance & deductible, and any outstanding balances. We reserve the right to reschedule your appointment until such payment is made. For your convenience, our office accepts cash, debit/credit cards, and Apple Pay.

Non-Insured Patients:
Patients without insurance must pay the office visit fee prior to seeing the provider. Should additional services be recommended (i.e. injections, in-house testing, labs, etc.), you will be required to make full payment prior to receiving services.

No-Show Fee:
In the event that you need to reschedule/cancel your appointment, please call at least 24 hours in advance. Failure to show for your appointment or failure to reschedule/cancel your appointment at least 24 hours in advance will result in you being charged a $25 fee.

Collections:
Should your account have an outstanding balance, PrimeCare Family Practice will collect prior to you seeing the provider at your next visit.

Medical Records:
In accordance to Texas Law, our office requires a signed form for the release of medical records and/or billing records. PrimeCare Family Practice charges $25 for the first 25 pages and $0.25 for each additional page thereafter. Please allow 15 BUSINESS days (Monday-Friday) from the day the payment was received. According to HIPAA privacy law, you will need to show identification that you have legal rights to this information.

FMLA/Disability Forms:
PrimeCare Family Practice has a form fee of $75 which must be paid before they will be filled out. Please allow up to 5 BUSINESS days for us to complete all forms. PrimeCare Family Practice does not certify disability nor fill out any forms related to disability.

Dental Complaints / Motor Vehicle Accidents / Personal Injury:
PrimeCare Family Practice does not file to third party companies. For you to see a provider under the above circumstances, you must be a self-pay patient, which includes the charges for the office visit and any additional testing, etc. There is no guarantee that you will be reimbursed for these expenses if you submit them to the third party.

Workers' Compensation:
PrimeCare will not see any workers' compensation or work-related cases regardless of whether you intend to file a workers' compensation claim or not.

Assignment of Benefits (required to file insurance):
I hereby assign all medical benefits to which I am entitled to PrimeCare Family Practice and any of its subsidiaries. I hereby authorize my insurance carrier to issue payments directly to PrimeCare Family Practice for medical services rendered to myself regardless of my insurance benefits. I understand that I am responsible for any amount NOT covered by my insurance.

Authorization of Release of Information (required to file insurance claims):
I hereby authorize PrimeCare Family Practice to (1) release any information necessary to insurance carriers regarding my illness and treatment; (2) process insurance claims generated in the course of examination and treatment; and (3) I allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

_____ _____

Signature Date

_____

Printed Name

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OFFICE POLICIES

1. Office hours are 8:30am-4:30pm Monday through Thursday and 8:30am-1pm Friday. We are closed for lunch between 12pm-1pm Monday through Thursday.
2. If you arrive 10 minutes or more after your scheduled appointment time, you may be asked to reschedule.
3. Twenty-four (24) hour notice is expected for appointment cancellations and/or rescheduling or you will be charged a $25 fee. Multiple late cancellations/reschedules and/or no call/no show appointments will result in termination from the practice.
4. Co-payments, coinsurance, deductible and self-pay payments are due at the time of service. No balance will be kept on patient accounts. Payments forms accepted are: Cash, MasterCard, Visa, Discover, American Express and Apple Pay.
5. All insurance claims will be filed electronically. Our office will make every effect to file your claim in a manner that is acceptable to your insurance company. If your insurance does not cover a certain procedure, treatment or in-house testing, the claim balance will become your responsibility. A statement will be mailed to your provided address.
6. All insurances cover prescriptions differently. It is your responsibility to work with your insurance to find an acceptable medication(s) for us to prescribe.
7. Patients with balances over $200.00 will NOT be scheduled for any future appointments until substantial payments are made in full.
8. Once the Medical Assistant/Nurse begins an encounter (vitals taken, notes started, etc.), no refunds will be made.
9. PrimeCare Family Practice does not manage chronic pain, nor do we typically prescribe benzodiazepines for anxiety/ insomnia. Examples of these medications include Norco (hydrocodone), Ultram (tramadol), Tylenol 3/4 (Tylenol with codeine), Xanax (alprazolam), Klonopin (clonazepam), Valium (diazepam), Ativan (lorazepam), Restoril (temazepam), and Soma (carisoprodol).
10. Our preferred method of communication is through the patient portal or you may call our office and speak with the medical assistant. If you need further assistance, you will need to schedule an appointment to speak with the provider directly.

I acknowledge that I have read and understand the above clinic policies and that all of my questions have been answered to my satisfaction. I understand that these policies are subject to change at any time. PrimeCare Family Practice will provide an updated list of office policies at your next office visit if updates are made.

_____ _____

Signature Date

_____

Printed Name

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TEXAS Health and Human Services | Texas Department of State Health Services

TEXAS IMMUNIZATION REGISTRY (ImmTrac2)
ADULT CONSENT FORM

(Please print clearly)

First Name _____ Middle Name _____ Last Name _____

Date of Birth (mm/dd/yyyy) _____ ( ) Telephone _____ Email address _____ Gender: ☐ Female ☐ Male

Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

The Texas Immunization Registry is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates immunization records for public health purposes (e.g., giving all doctors treating a patient a central place to see that patient's immunization records). With your consent, your immunization information will be included in ImmTrac2. *For a family member younger than 18 years of age, a parent, legal guardian, or managing conservator may grant consent for participation for that minor by completing the ImmTrac2 Minor Consent Form (# C-7) available for downloading at www.ImmTrac.com.*

Consent for Registration and Release of Immunization Records to Authorized Persons / Entities

I understand that, by granting the consent below, I am authorizing release of my immunization information to DSHS and I further understand that DSHS will include this information in the Texas Immunization Registry. Once in ImmTrac2, my immunization information may by law be accessed by: a Texas physician, or other health care provider legally authorized to administer vaccines, for treatment of the individual as a patient; a Texas school in which the individual is enrolled; a Texas public health district or local health department, for public health purposes within their areas of jurisdiction; a state agency having legal custody of the individual; a payor, currently authorized by the Texas Department of Insurance to operate in Texas for immunization records relating to the specific individual covered under the payor's policy. **I understand that I may withdraw this consent at any time.**

State law permits the inclusion of immunization records for First Responders and their immediate family members (older than 18 years of age) in the Registry. A "First Responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency. An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the First Responder. For a family member younger than 18 years of age, a parent, legal guardian, or managing conservator may grant consent for participation as an "ImmTrac2 child" by completing the Immunization Registry (ImmTrac2) Consent Form (# C-7).

Please mark the appropriate box to indicate whether you are a First Responder or an Immediate Family Member.

☐ I am a FIRST RESPONDER. ☐ I am an IMMEDIATE FAMILY MEMBER (older than 18 years of age) of a First Responder.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my information in the Texas immunization registry.

Individual (or individual's legally authorized representative): _____ Printed Name

_____ Date _____ Signature

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.texas.gov for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com

Texas Department of State Health Services • ImmTrac Group • MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in ImmTrac2 and **affirm** that consent has been granted. **DO NOT fax to ImmTrac2. Retain this form in your client's record.**

PRIME CARE
FAMILY PRACTICE

MEDICAL RECORDS RELEASE FORM

Patient Name: _____ Date of Birth: _____

Physician/Entity: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ Fax: _____

I hereby request that my medical records be released to:
Maryline Ongangi, FNP
Lewis Nyantika, FNP
Dr. Eberechi Anozie
1001 N. Waldrop Dr., Ste 801
Arlington, TX 76012
Phone: 817-962-0056
Fax: 817-962-0057

Secure email: patientcare@primecarefp.com (preferred method)

_____ _____ _____ _____
Signature Printed Name Date