Medical Colleagues of Texas, LLP

Patient Information

SS#:_____ **First:** _____ **Middle Initial:** ____ **Last:** _____

Sex: ____ **DOB:** _____ **Marital Status:** ☐ **Minor** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widow** ☐ **Separated**

Race / Ethnicity _____ **Language** _____

Employment Status: ☐ **Unemployed** ☐ **Retired** ☐ **Student** ☐ **Employed** **Employer:**_____

Patient Address: _____ **City:**_____ **State:**_____ **Zip:**____

Email: _____ **Home Phone:** _____ **Work Phone:** _____ **Cell:**_____

Referring Provider: _____ **How did you hear about us:** _____

Preferred Pharmacy: _____ **Phone:** _____ **Location:**_____

Emergency Contact: _____ **Relationship:**_____ **Cell:** _____ **Home:**_____ **Work:**_____

Responsible Party

Name of Person Responsible for this Account: _____ **Relationship to Patient**_____

Address (**if different from patient's**): _____

Cell :_____ **Home Phone:**_____ **DOB**_____ **SSN:**_____

Employer: _____ **Work Phone:**_____

Have we seen other members in your family? ☐ **No** ☐ **Yes** **Name:**_____ **DOB:** _____

Insurance Information

Insured/Care Holder's Name: _____ **Relationship to Patient:**_____

DOB:_____ **SSN:**_____ **Employer:** _____

Insurance Company: _____ **Group#:** _____ **Policy/ID #:** _____

Address:_____ **Provider Ins. Verification Phone #:**_____

DO YOU HAVE ADDITIONAL INSURANCE? YES NO (If YES, Please Complete the Following)

Name of Insured _____ **Relationship to Patient:**_____

DOB:_____ **SSN:**_____ **Employer:** _____

Insurance Company: _____ **Group#:** _____ **Policy/ID #:** _____

Address:_____ **Provider Ins. Verification Phone #:**_____

PLEASE HAVE YOUR INSURANCE CARD AND DRIVER'S LICENSE AVAILABLE

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I authorize my insurance company to pay and hereby assign to Medical Colleagues of Texas, LLP all benefits payable for services rendered. I understand I am financially responsible to pay non-covered services.

_____
Signature (Patient or Parent if Minor) Date

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information required in the course of my treatment necessary to process insurance claims.

_____
Signature Date

Financial Policy of Medical Colleagues of Texas, LLP

Thank you for choosing Medical Colleagues of Texas to provide your health care. Our main concern is that you receive the proper treatment needed. In order to prevent any misunderstandings and to serve you better, we ask that all patients read and sign our financial policy. If you have any questions or concerns about our policies, please do not hesitate to ask.

1. As a courtesy we will file your insurance if you are a member of an insurance plan with which we are contracted. If you are not able to provide us with a valid insurance card, you will be required to pay cash for your visit. If your insurance has changed since your last visit, please inform us **BEFORE** your visit, and present us with your new card so that we may verify your coverage and benefits. If you do not inform us of any changes and we have not been able to collect from your previous insurance, you will be responsible for any unpaid balance. Most insurance plans require that a claim be filled within 90 days from date of service. Please remember that all charges are your responsibility whether or not your insurance pays.

PAYMENT IS DUE AT THE TIME SERVICE IS RENDERED.
WE ACCEPT CASH, VISA, MASTERCARD, AND PERSONAL CHECKS.

2. FIXED CO-PAYS WILL BE COLLECTED AT THE TIME OF YOUR VISIT. Inability to make payment at that time may require us to reschedule your visit. Deductibles, co-pays, co-insurance and non-covered services must be paid at the time the service is provided.

3. Charges incurred that are subject to a yearly deductible are due at the time of service. Deductibles and co-insurance amounts are determined and due prior to any procedure. Any overpayment will be promptly refunded.

4. MEDICARE PATIENTS: It can be considered Medicare fraud to waive deductibles and co-payments. Therefore, deductibles and co-payments will be collected at the time of service. We accept and file claims for "Medigap" secondary insurance plans; however, if we do not receive payment or an explanation of benefits within 30 days, the balance will be billed to you. It will be your responsibility to call your insurance company to determine the status.

5. SHOT RECORDS: Shot records will be furnished at no charge the first time. Duplicate records will be assessed a $10.00 fee.

6. MISSED APPOINTMENTS: If you are unable to make your appointment, notice needs to be given to us 24 hours in advance. If you miss your appointment without proper notification, you may be charged a "missed appointment fee" in the amount of $25.00.

7. RETURNED CHECKS will incur a $30.00 fee. The amount of the check, plus the fee must be paid within 10 days of notification by money order, cash or credit card to prevent further action. If a second check is returned on your account, we will no longer be able to accept personal checks as payment.

8. There will be a $25.00 pre-payment fee for completion of forms for "FMLA," disability, etc.

Patient Name _____ **DOB** _____
(Print Please)

_____ _____
Signature **Date**

Medical Colleagues of Texas, LLP
Acknowledgment and Consent of
Notice of Privacy Practices

I understand that **Medical Colleagues of Texas'** Notice of Privacy Practices, which explains how my medical information will be used and disclosed, is posted in the waiting room. I understand that I am entitles to receive a copy of this document if requested.

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 communication or that communication of PHI be made by alternative means, such as leaving a message on answering machines, discussing your health information with someone other than yourself, and by communicating with you through electronic communication.

Personal Contact Information

Home phone#: _____ Cell Phone #: _____

Work Phone #: _____ May we leave a message? ____Yes ____No

Other than yourself, whom may we talk to about or leave medical information with?

Name: _____ Relationship: _____

Home #: _____ Cell #: _____Work #: _____

Email Communication Consent

This office has established a **practice portal** for secure messaging. This allows you to communicate with us for reasons such as requesting appointments, requesting refills, billing questions, changing personal information, or paying your balance. This method of communication is not appropriate in an emergency, nor is it intended to provide medical care via email. Medical questions that require decision making should be addressed during an office visit. To begin using these services, you will need to create a **secure account on our website**. Ask the receptionist for a letter with your person pin and detailed information. It is important that you check your email for notices from the practice portal regularly. Please be aware that using email without an account through our website may not be secure; therefore, we recommend that you only communicate with us through our practice portal.

By signing below, I authorize **Medical Colleagues of Texas** to use and disclose my medical information for the Purpose of Treatment, Payment, and Health Care Operations and agree that **Medical Colleagues of Texas** may send medical related correspondence to me via practice portal if I decide to participate.

_____ _____

Signature of Patient or Authorized Representative **Date**

_____ _____

Printed Name of Patient **Patient's Date of Birth**

Name _____ Date _____

Date of Birth _____

Reason for Visit _____

_____

Past Medical History - Please check all of the following that apply to YOU and indicate the year if applicable.

- ☐ Atrial fibrillations
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Past heart attacks
- ☐ Congestive heart failure
- ☐ Heart valve replacement
- ☐ Heart murmurs
- ☐ High cholesterol
- ☐ Multiple sclerosis
- ☐ Seizures
- ☐ Migraines
- ☐ TIA (Transient Ischemic Attack)
- ☐ Strokes
- ☐ COPD
- ☐ Emphysema
- ☐ Chronic bronchitis
- ☐ Asthma
- ☐ Pulmonary blood clot
- ☐ Sleep apnea
- ☐ Diabetes Mellitus type I
- ☐ Diabetes Mellitus type II
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Goiter (enlarged thyroid)
- ☐ Acid reflux
- ☐ Hiatal hernia
- ☐ Gastric ulcers
- ☐ Hepatitis
- ☐ Ulcerative colitis
- ☐ Crohn's disease
- ☐ Diverticulitis of colon
- ☐ Arthritis
- ☐ Blood disorder
- ☐ Kidney disorder
- ☐ Enlarged prostate
- ☐ Depression
- ☐ Anxiety
- ☐ Cancer: _____

  _____
- ☐ Other: _____

  _____

Past Surgical/Procedural History - Please check all that apply and indicate the year if applicable.

- ☐ Cardiac bypass
- ☐ Valve replacement
- ☐ Tonsils removed
- ☐ Thyroid surgery
- ☐ Gallbladder removed
- ☐ Appendix removed
- ☐ Hernia repair
- ☐ Nephrectomy (kidney)
- ☐ Partial colectomy (colon)
- ☐ Small bowel resection
- ☐ Splenectomy (spleen)
- ☐ Colonoscopy
- ☐ Endoscopy
- ☐ Echocardiogram
- ☐ Stress test
- ☐ Back surgery
- ☐ Hip surgery
- ☐ Knee surgery
- ☐ Shoulder surgery
- ☐ Foot surgery
- ☐ Hand surgery
- ☐ Cataract surgery
- ☐ Lung surgery
- ☐ Other _____

  _____

Medications - Please list all current medication and doses:

_____

_____

_____

_____

_____

_____

_____

_____

Please list all Vitamins & Supplements

_____

_____

Allergies: _____

_____

_____

_____

Please Complete Back side

Social History - Please check all that apply and indicate frequency and duration, if applicable

- ❒ Alchohol use _____
- ❒ Smoking _____
- ❒ Elicit drugs _____
- ❒ Caffeine _____
- ❒ Chewing tobacco _____
- ❒ Living arrangements _____
- ❒ Marital status _____
- ❒ Occupation _____
- ❒ Exercise _____

Family medical history - Please check all that apply to members of your immediate family (parents, grandparents, siblings) and indicate whom

- ❒ Heart disease
- ❒ Past heart attacks
- ❒ High blood pressure
- ❒ High cholesterol
- ❒ Diabetes mellitus
- ❒ Arthritis
- ❒ Blood disorder
- ❒ Thyroid disorder
- ❒ Kidney disorder
- ❒ Dementia
- ❒ Alzheimer's disease
- ❒ Cancer: _____
- ❒ Other: _____

Men Only:

- ❒ Prostate surgery
- ❒ Vasectomy
- ❒ Digital Rectal Exam

Women Only:

- ❒ Hysterectomy
- ❒ Breast lumpectomy
- ❒ Breast mastectomy
- ❒ Breast reconstruction
- ❒ Tubal ligation
- ❒ Caesarian section
- ❒ Breast biopsy

Women Only:

#of pregnancies _____
# of births _____
# of miscarriages/abortions _____
Date of last menstrual cycle _____
Date of menopause onset _____
Date of last pap smear _____
Normal or Abnormal? _____
Date of last mammogram _____
Normal or Abnormal? _____
Date of last bone density scan _____
Normal or Abnormal? _____