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**

Patient's Name ______________________________ DOB __________

Bethany A. Peterson, M.D.
Kelly Anne McCullagh, M.D.
Tiffany M. Mullin, M.D.
Jane Ellis, RNC-NP

PERSONAL HISTORY

HAVE YOU EVER HAD...(CIRCLE ALL THAT APPLY)

GERMAN MEASLES	HEART ATTACK	DIABETES
MIGRAINE HEADACHES	HEART MURMUR	KIDNEY STONE
PROLONGED DIZZINESS	RHEUMATIC FEVER	KIDNEY INFECTION
GLASSES OR CONTACATS	OTHER HEART DISEASE	OTHER KIDNEY DISEASE
DENTURES	HIGH BLOOD PRESSURE	ARTHRITIS
THYROID TROUBLE	BREAST TUMOR	PARALYSIS
PNEUMONIA	ULCER	NEUROLOGIC DISEASE
ASTHMA	HEPATITIS	THROMBOPHLEBITIS - Clots in legs
OTHER LUNG DISEASE	INTESTINAL BLEEDING	MITRAL VALVE PROLAPSE

WITH RESPECT TO YOUR FEMALE ORGANS, HAVE YOU EVER HAD...(CIRCLE ALL THAT APPLY)

ABNORMAL BLEEDING	TUBAL (ECTOPIC PREGNANCY)
HERPES INFECTION	INFECTION OF THE TUBES OR OVARIES
GONORRHEA OR SYPHILIS	ABNORMAL PAP SMEAR

GENETIC: IF YOU OR YOUR HUSBAND ARE IN THE FOLLOWING CATEGORIES PLEASE RESPOND.

BLACK/INDIAN - HAVE YOU AND/OR YOUR HUSBAND HAD SICKLE CELL CARRIER TESTING? __________

ITALIAN/GREEK - HAVE YOU AND/OR YOUR HUSBAND HAD THALASSEMIA CARRIER TESTING? __________

JEWISH - HAVE YOU AND.OR YOUR HUSBAND HAD TAY-SACHS CARRIER TESTING? __________

DO YOU DO YOUR OWN MONTHLY SELF BREAST EXAMINATIONS? __________

DO YOU DRINK ALCOHOL? ______ IF YES, ESTIMATE, NUMBER OF DRINKS, BEERS OR GLASSES OF WINE PER ______ WEEK ______ DO YOU SMOKE? ______ HOW MUCH? ______ ARE YOU USING ANY OTHER DRUGS?

TYPE ____

FAMILY HISTORY: IS THERE A MEMBER OF YOUR FAMILY WITH A HISTORY OF

- DIABETES WHO? __________________
- HEART DISEASE WHO? __________________
- HIGH BLOOD PRESSURE WHO? __________________
- KIDNEY DISEASE WHO? __________________
- CANCER WHO? __________________
- CONGENITAL (INHERITED) DISEASE WHO? __________________

IF YOU ARE PREGNANT, DO YOU DESIRE INFORMATION ON PERMANENT STERILIZATION? __________

REASON FOR THIS VISIT? ____

____

WHAT LED YOU TO COME IN NOW, RATHER THAN LAST MONTH OR NEXT MONTH? __________

____

HOW DO YOU HOPE THAT I MIGHT HELP YOU TODAY? ______________________________

____

Bethany A. Peterson, M.D.
Kelly Anne McCullagh, M.D.
Tiffany M. Mullin, M.D.
Jane Ellis, RNC-NP

DATE ____________ NAME ____ AGE _____

PREGNANCIES _____ DELIVIERIES ______ MISCARRIAGES _____ ABORTIONS ______ LIVING CHILDREN ________

LAST MENSTRUAL PERIOD ________________________ LAST MAMMOGRAM RESULTS ______________________

ARE YOUR PERIODS IRREGULAR? ___________________ ANY PROBLEMS WITH PERIODS? __________________

____

DATE OF LAST PAP SMEAR ____ RESULTS _____________

HAVE YOU EVER HAD AN ABNORMAL PAP? _______ IF YES, HOW AND WHEN WAS IT TREATED? _______________

ARE YOU SEXUALLY ACTIVE? ____________ DO YOU THINK YOU MIGHT BE PREGNANT? ____________________

CURRENT TYPE OF CONTRACEPTION? ________ DO YOU WANT TO CHANGE? ______ TO WHAT? _______________

DID YOUR MOTHER TAKE THE DRUG **DES** OR OTHER HORMONES WHILE PREGNANT WITH YOU? _______________

LIST ALL CURRENT MEDICATIONS

LIST ALL ALLERGIES TO MEDICATIONS

LIST ALL SURGERIES

TYPE OF SURGERY	APPROXIMATE DATE

LIST PREVIOUS PREGNANCIES IN CHRONOLOGICAL ORDER - INCLUDING MISCARRIAGES OR ABORTIONS

YEAR	SEX	WEIGHT	HOURS IN LABOR	CAESAREAN SECTION OR VAGINAL	COMPLICATIONS