NEW PATIENT QUESTIONNAIRE

Name:_____Today's Date:_____

Date of Birth:_____Age:_____Social Security #:_____

Occupation:_____Race:_____ Marital Status:_____

Home Address:_____

City:_____State:_____Zip:_____

Home Phone:_____Cell Phone:_____Work:_____

Employer:_____Email Address:_____

Minor Information

Legal parent or guardian:_____ Relationship:_____

Cell Phone:_____Work:_____Home Phone:_____

In Case of Emergency Contact:_____Relationship:_____

Cell Phone:_____Home Phone:_____

Work:_____

Method of Payment (circle one): Insurance Self Pay Medicare

Insurance Provider: _____Name of Insured:_____

Insured's Employer: _____ Policy #:_____

Group #:_____

Provider Preference: (circle one)

Tad Titlow, FNP-C *Michael Colotta, FNP-C* *Sally Thompson, FNP-C*

Dyllon Sanford, PA

MEDICAL HISTORY

Height:_____ Weight:_____ Last Menstrual Period:_____

Hysterectomy? ( ) No ( ) Partial ( ) Full

Do you smoke? ( ) Yes ( ) No ( ) Quit How much?_____ How often?_____

Do you drink alcohol? ( ) Yes ( ) No ( ) Quit How much?_____ How often?_____

Any known drug allergies: ( ) Yes ( ) No If yes please explain:_____

_____

Pharmacy: : _____

Current Hormone Replacement Therapy:_____ Past HRT: _____

Surgeries, list all and Year:

_____

_____

_____

_____

Do you have a personal history of? **Check all that apply.**

Preventative Medical Care:
( ) Medical/GYN Exam in the last year
( ) Mammogram in the last 12 months
( ) Bone Density in the last 12 months
( ) Pelvic ultrasound in the last 12 months

High Risk Past Medical/Surgical History:
( ) Breast Cancer
( ) Uterine Cancer
( ) Ovarian Cancer
( ) Hysterectomy with removal of ovaries
( ) Hysterectomy only
( ) Oophorectomy Removal of Ovaries
( ) Prostate Cancer

Birth Control Method:
( ) Menopause
( ) Hysterectomy
( ) Tubal Ligation
( ) Birth Control Pills
( ) Vasectomy
( ) Other:

Medical Illnesses:
( ) High blood pressure
( ) Heart bypass
( ) High cholesterol
( ) Hypertension
( ) Heart Disease
( ) Stroke and/or heart attack
( ) Blood clot and/or a pulmonary emboli
( ) Arrhythmia
( ) Any form of Hepatitis or HIV
( ) Lupus or other auto immune disease
( ) Fibromyalgia
( ) Trouble passing urine or take Flomax or Avodart
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis)
( ) Diabetes
( ) Thyroid disease
( ) Arthritis
( ) Depression/anxiety
( ) Psychiatric Disorder
( ) Cancer Type: Year:

PRINT NAME **SIGNATURE**

Patient Responsibility Form

Insurance:

- The patient is responsible for providing Henderson Family Medicine with the most correct, active, and updates information about their insurance prior to each visit.
- Henderson Family Medicine will bill to the insurance most recently provided by the patient with the assumption it is correct. If the information given by the patient is inacurrate and denied, the patient will be responsible for the balance of the visit. Please be aware that with some insurance companies, we do run into timely filing deadlines so providing correct information at the time of service is critical so we can accurately bill the patient's insurance. Timely filing means the patient's insurance plan may not pay the claim after a certain amount of time after the service.
- Patient's are responsible for the payment of co-pays at the time of service.
- Patient's are responsible for paying any applicable co-insurance, deductibles, all other procedures, and treatments not covered by their insurance plan.
- The patient is responsible for knowing what their plan does and does not cover. If the patient has questions about their plan and what services are covered, they should contact their insurance (typically support phone numbers are on the back of your insurance card)
- In the event the patient's health determines a service to be "not payable", the patient will be responsible for the complete charge and agrees to pay the cost of all services provided.
- Henderson Family Medicine is not responsible for knowing what each individual patient's insurance plan does and does not cover.
- Patient's have the right to checkwith their insurance about coverage before any treatment occurs at Henderson Family Medicine.
- It is important for patient's to be informed comsumers, who understand the specifications of their insurance policy (i.e vaccine and doctor visit coverage, referral/authorization requirements for specialty care, radiology, laboratory tests, etc)
- The patient's health insurance policy is a contact between the patient and their health insurance company or employer. It is the patient's responsibility to know their insurance's specific rules or regulations such as referrals, pre-certifications, pre-authorizations, and limits on outpatient charges regardless of whether or not our providers participate.
- Henderson Family Medicine accepts most major insurance plans EXCEPT Medicaid, Workers Compensation, and Automobile claims.
- The patient is responsible for knowing if our doctor is in-network with their insurance plan and if the services are covered under the patient's plan.
- If the patient choses to self-pay for services instead of filing on insurance (due to high deductible) it is the PATIENT'S responsibility to tell Henderson Family Medicine at the time of service.
- If the patient is uninsured, the patient agrees to pay for the medical services rendered to them at the time of service.

Address/Demographic Changes:

- It is important that we have the patient's correct address/phone information on file.
- The patient is responsible for alerting Henderson Family Medicine to any address, phone, or other demographic changes.

Billing:

- If the patient owes additional money after their visit, they can expect to receive a statement.
- To keep healthcare costs down, the patient should attempt to pay their bill upon the receipt. Just as wemake every effort to accommodate patient's when they are in need of medical care, we expect that patient's will make effort to pay their bill promptly. Payment is due at the time services are provided or upon the receipt of statement from out billing office.

Scheduling:

- If you have 3 "No-Show/Missed" appointments within a 12-month time period or you have 3 consecutive "No-Show/Missed" appointments; you will receive a notice from our clinic stating that you will not be able to schedule any future appointments with our clinc.

Medicare Patient's:

- Medicare patient's request payment of authorized Medicare benefits to them or on their behalf for any services furnished them by Henderson Family Medicine. Medicare patients authorize any holder of medicl or other information about them to

release to Medicare and it's agents any information needed to determine these benefits or benefit related services.

- Medicare may not cover some of the services that the patient's provider recommends. The patient will be informed ahead of time and given an Advanced Beneficiary Notice (ABN) to read and sign. The ABN will help the patient decide whether they wish to receive the services, knowing they are responsible for payment. Patient's must read the ABN carefully.

Minors:

- Patient's who are under the age of 18 need parent/guardian consent for their appontment. By signing this agreement, the parent/guardian acknowledges all of the information on this form on behalf of the patient. It is strongly recommended that the parent/guardian accompany the minor to their appointment. In the event a parent/guardian is unable to accompany the minor and the minor is coming alone, it is required that the parent/guardian call us at (903)392-8259 to let us know and give a verbal permission to signing this form, if a procedure/treatment will occur, we need to be able to contact the parent/guardian. Please list the names and relationship of parent/guardian who may seek treatment for the minor patient.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Financial Agreement:

- The patient agrees that in return for the services provided to them by Henderson Family Medicine they will pay their account at the time service is rendered or upon insurance claim processing. If payment plan consideration is necessary, the patient understands that it is their responsibility to call and make financial arrangements satisfactory to Henderson Family Medicine for payment. If co-payments, co-insurance, and/or adjustments are assigned by the patient's insurance company or health plan, they aggree to pay them to Henderson Family Medicine.

Failure to pay:

- Patients who ignore collection notices/letters and fail to pay their balance risk negative credit ratings and possible dismissal from the practice.
- Past due accounts may hinder your ability to have appointments scheduled.

Guarantor:

- Any patient over the age of 18 will be held financially responsible for all charges incurred. If another party is responsible for payment of the patient's account, please advise us who to send the statements to. The patient must pay the balance in full and negotiate repayment with anybody not listed with us as a guarantor outside of our office. This policy includes individuals negotiating divorce settlements.

_____

Print name of Patient

_____

Signature of Patient or Parent/Guardian Date

Henderson Family Medicine, PLLC

Patient Consent to Use and Disclosure of Protected Health Information

With my consent, Henderson Family Medicine, PLLC, may use and disclose Patient Health Information (PHI) about me to carry out Treatment, Payment, and Healthcare Operations (TPO). Please refer to Henderson Family Medicine, PLLC Notice of Privacy Practices for more complete description of such uses and disclosures. I have the right to request that Henderson Family Medicine, PLLC restrict how it uses or discloses my PHI to carry out TPO.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Henderson Family Medicine, PLLC reserves the right to revise it's Notice Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by signing a written request in our office or by forwarding a written request to the Office Manager, 105 N High Street Henderson, TX 75652

With my consent, Henderson Family Medicine, PLLC may email, mail to my home, or another alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements.

With my consent, Henderson Family Medicine, PLLC may call my home, cell phone, or other designated locations and leave a message on voicemail or answering machine in reference to any items that will assist the practice in carrying out TPO, such as appointment reminders, insurance items, information pertaining to my clinical care, and laboratory results among others.

By signing this form, I am consenting to Henderson Family Medicine, PLLC to use and disclose of my Patient Health Information (PHI), to carry out Treatment, Payment, and Healthcare Operations (TPO) as specified above.

I may revoke my consent in writing at any time with the understanding that my information may have already been disclosed to carry out previous TPO.

Today's Date:_____

Signature of Patient or Guardian:_____

I give consent for Henderson Family Medicine, PLLC to leave medical information with, or contact in an emergency, the following person(s) if I am unavailable: :

Name:_____ Relationship:_____

Phone number:_____

Name:_____ Relationship:_____

Phone number:_____

Informed Consent for Telehealth Services

I _____ consent to engaging in telehealth with Henderson Family Medicine as part of my healthcare in meeting my treatment goals. I understand that telehealth may include health evaluation, assessment, consultation, and treatment planning. Telehealth will occur primarily through interactive audio, video, telephone, and/or other audio/video communications.

I understand I have the following rights with respect to telehealth:

1. **I have the right to withhold or remove consent at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any benefits to which I would otherwise be eligible.**
2. **The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during the course of my sessions is generally confidential. There are both mandatory and permissive exceptions to confidentiality including but not limited to reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as part of legal proceedings where information is requested by a court of law. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.**
3. **I understand that there are risks and consequences from telehealth including but not limited to, the possibility, despite reasonable efforts on the part of Henderson Family Medicine that the transmission of my personal information could be disrupted or distorted by technical failures and/or he transmission of my personal information could be interrupted by unauthorized persons. In addition, I understand that the telehealth based services and care maynot be as complete as in-person services. I understand that if my provider believes I would be better served by face to face service, I would be referred by to the standard of care conducted in the office setting.**
4. **I understand that I have the right to access my personal information and copies of my office notes. I have read and understand the information provided above. I have discussed these points with my provider, and all of my questions regarding the above matters have been answered to my satisfaction.**
5. **By signing this document I agree the certain situations, including emergencies, are innappropriate for audio/video/telephone services. If I am in an emergency I understand I should immediately call 911 or go to the nearest Hospital.**

By signing this document, I hearby authorize Henderson Family Medicine to use telemedicine in the course of my diagnosis and treatment.

_____

Signature of Patient or Guardian Date

_____

Printed name of Patient Relationship (if applicable)