TOTAL FAMILY CARE

NEW PATIENT REGISTRATION FORM

ALIEF ISD? (please circle one) YES / NO	**PCP:**
How did you hear about us?	

PATIENT INFORMATION

Patient's last name	**First**	**M.I**	**Date of Birth** / /

Would you like access to our Patient Portal? (if so, we need your email) ❑ Yes ❑ No ***Email address for your portal:***	Marital Status ❑Single ❑Married ❑Separated ❑ Widowed	Preferred way of communication ❑Phone call ❑Text message ❑Email ❑Patient Portal	Sex ❑ M ❑ F

Street address:	**Social Security number:** - -

City	**State**	**Zip code**	**Phone number** - -

Race American Indian / Asian / African American / White / Other Race	**Ethnicity** Hispanic/Latino / Not Hispanic or Latino

Pharmacy name: _____

Phone number: _____

Pharmacy city and/or zip code: _____

INSURANCE INFORMATION

(Please give your insurance card & ID to the receptionist.)

❑ Multiplan ❑Medicare ❑ Aetna ❑ Blue Cross Blue Shield ❑ Cigna ❑ Humana ❑ United Health Care

Subscriber's name:	Birth date: / /	Member ID #	PCP:	Co-payment: $

IN CASE OF EMERGENCY

Contact:	Relationship:	Phone:	Email:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian Signature **Date**

AUTHORIZATION – NON-PARENT/GUARDIAN TO ACCOMPANY PATIENT (MINOR)

❑ *NO ONE OTHER THAN THE PARENT(S) IS ABLE TO BRING MY CHILD(REN) TO THE CLINIC.*

Periodically there may be times when you are unable to bring your child to the office for an appointment and need to rely on a family member or friend. We understand these circumstances; however, we must have a written authorization letter allowing this person to accompany your child(ren). The person bringing your child will need to present photo identification at time of service.

This authorization gives the person permission to bring your child(ren) in, speak to the doctor, given authorization for treatment, vaccinations, medication, and certain procedures and make general health decisions.

I, _____, give the person(s) listed below permission to bring my child to Total Family Care and to discuss and share medical information about my child. I further authorize them to see all necessary medical records and make health care decisions of a routine nature as determined at the sole discretion of the provider.

I also give them authority to make more serious or urgent health care decisions in the event that I cannot be reached or where it is of an emergency nature where there is not sufficient time to seek of my specific consent.

Child's name: _____ DOB: _____
Child's name: _____ DOB: _____
Child's name: _____ DOB: _____

Limitations(if any): _____
_____
_____

Name of person authorized: _____ Relationship: _____
Name of person authorized: _____ Relationship: _____
Name of person authorized: _____ Relationship: _____

_____

Parent/Guardian Signature Date

TOTAL FAMILY CARE

NEW PATIENT HEALTH HISTORY

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

NAME: ☐ M ☐ F	**DATE:**
DOB:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

CHILDHOOD ILLNESS: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

☐ Diabetes	☐ Kidney Disease	☐ Depression
☐ High Cholesterol	☐ Bladder Problems	☐ Anxiety
☐ Thyroid Disease	☐ Prostate Problems	☐ Psychiatric
☐ High Blood Pressure	☐ Asthma	☐ Arthritis
☐ Heart Attack	☐ Chronic Bronchitis	☐ Osteoporosis
☐ Angina/Chest Pain	☐ Emphysema	☐ Gout
☐ Congestive Heart Failure	☐ Allergies	☐ Back Problems
☐ Other Heart Disease	☐ Pneumonia	☐ Eye Problems
☐ Other Lung Disease	☐ Ear Problems	☐ Hiatal Hernia
☐ Bleeding/Clotting Disorder	☐ Stroke	☐ Liver Disease
☐ Seizures/Epilepsy	☐ Stomach Ulcers	☐ Anemia
☐ Disease of the Colon	☐ Hemorrhoids	☐ Head Injury
☐ Accidents/Broken Bones	☐ Cancer _____	☐ Other _____

PLEASE LIST ANY FAMILY HISTORY BELOW

SURGERIES

Year	Reason	Hospital

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING VITAMINS AND/OR HERBAL SUPPLEMENTS/REMEDIES

Name	Dose/Strength	Frequency Taken

LIST ANY ALLERGIES TO MEDICATIONS, FOOD, OR LATEX	
Name the Drug	Reaction

Exercise	☐ No				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you currently dieting?			☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	_____ cups/cans per day?				
Alcohol/ Tobacco	Do you drink alcohol?			☐ Yes	☐ No
	How many drinks per week? _____				
	Do you smoke tobacco?		_____ packs/day	_____ years	Want to stop? _____

PLEASE USE THIS SPACE TO INDICATE ANY OTHER HEALTH HISTORY THAT THE PHYSICIAN SHOULD KNOW ABOUT. THANK YOU.

ASSIGNMENT OF BENEFITS

FINANCIAL RESPONSIBILITY

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our billing department or manager. Necessary forms will be completed to file for insurance carrier payments.

ASSIGNMENT OF BENEFITS

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment check(s) directly to Total Family Care for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Total Family Care to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) 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.

I have requested medical service from Total Family Care on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/Responsible Party Signature **Date**

_____ _____

Witness Date

TOTAL FAMILY CARE

CONSENTS AND NOTICES

IMPORTANT: Please read carefully.
Initial each line to indicate that you have read the statement

_____ **CONSENT FOR MEDICAL SERVICES & TREATMENT**

I consent to treatment, diagnostic and/or therapeutic services as ordered and/or provided by the physicians and ancillary providers of Total Family Care and/or its designee(s).

_____ **NOTICE OF APPOINTMENT POLICY**

CANCELLING OR RESCHEDULING:

You must give our office at least 24 hour notice when cancelling or rescheduling an appointment. Appointments that are cancelled or rescheduled with less than 24 hour notice will result in a $25 charge to the patient. You can call, or **text**, us to let us know as long as it is the day before.

_____ **LATE ARRIVAL POLICY:**

If you arrive more than 10 minutes late for your scheduled appointment time, we must reschedule your appointment and you will be charged a $25 No-Show/rescheduling fee.

_____ **MISSED APPOINTMENTS:**

For missed appointments, resulting from a No-Show or a late arrival (> 10 minutes), you will be charged a $25 No-Show fee.

_____ Insurance companies **DO NOT** pay for missed/cancelled/rescheduled appointment fees. I understand and agree to all of the Notice of Appointment Policies.

_____ **NOTICE OF PRIVACY PRACTICES**

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices or have been directed to a copy of the same and that it was explained to me.

_____ _____

Patient/Guardian Name – Please print **Date**

_____ _____

Patient/Guardian Signature **Date**

TOTAL FAMILY CARE

PHONE CONSENT FORM

Your physician(s) and other staff members will, at times, need to contact you. By filling in the information below, we will be able to serve you better.

UNLESS WE HAVE YOUR WRITTEN CONSENT TO DO SO, WE WILL NOT:

- Leave messages with anyone except the patient or legal guardian.
- Leave information on an answering machine
- Leave information in a voicemail box

Please read below and consider carefully whom you want to have access to your medical information.

I give Total Family Care my permission to leave phone messages regarding my medical care and test results with the following individual(s) and/or answering systems. I fully understand that this consent will remain in effect until revoked in writing.

My cell phone: (_____) _____-_____ **initials** _____

My home answering machine/voicemail: (_____) _____-_____ **initials** _____

My office/work voicemail: (_____) _____-_____ **initials** _____

MY MEDICAL CARE MAY BE DISCUSSED WITH THE FOLLOWING:

My spouse: _____

at (_____) _____-_____ **initials** _____

OTHER: _____

at (_____) _____-_____ **initials** _____

_____ _____

Patient/Guardian Signature **Date**

TOTAL FAMILY CARE

CONSENT FOR INJECTION/PROCEDURE

I, _____ hereby consent to the rendering of such care, which may include routine procedures and such medical treatments including Therapeutic injections as the physician(s) consider being necessary under these circumstances. I authorize the physician(s) and other health care professionals to order and/or administer any treatment and/or perform such procedures as may be deemed necessary or advisable in the diagnosis and/or treatment of my injury or illness. This form has been fully explained to me, including risks, side effects, and benefits of treatment and I am satisfied that I understand its content and significance.

_____ _____

Patient Signature **Date**

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Witness Date

TOTAL FAMILY CARE

ACKNOWLEDGEMENT OF ROUTINE PHYSICAL AND/OR WELLNESS PREVENTATIVE OFFICE VISIT

I, _____ am aware that my insurance may not cover any or all charges associated with my wellness visit if the visit is conducted less than one year from my previous wellness visit or is not compliant with any other requirements per my individual policy. This is to include charges associated with the preventative blood work also. I may receive a bill in the mail in the form of an explanation of benefits (EOB) from my insurance plan for any charges that are not covered.

TOTAL FAMILY CARE IS NOT RESPONSIBLE FOR ANY CHARGES THAT MY INSURANCE WILL NOT COVER.

_____ _____

Patient Signature **Date**

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Witness Date

TOTAL FAMILY CARE

ACKNOWLEDGEMENT OF BLOOD TESTING

I, _____ am aware that my insurance may not cover *all blood testing*, including STD testing. I _____ will be fully responsible for any unpaid charges, for any blood work, that my insurance will not cover.

Any bill addressed from a laboratory will need to be handled with that laboratory

TOTAL FAMILY CARE IS NOT RESPONSIBLE FOR ANY TESTING THAT MY INSURANCE WILL NOT COVER.

_____ _____

Patient Signature **Date**

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Witness Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS DOCUMENT CAREFULLY. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT THE PRIVACY OFFICER.

OUR OBLIGATIONS

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

We may use and disclose health information that identifies you only for each of the following purposes: Treatment, payment, and health care operations. Except for the following purposes, we will use and disclose health information only with your written permission. You may revoke such permission at any time by writing to our Privacy Officer.

- Treatment means providing, coordination, or managing health care and related services by one or more health care providers. An example of this would include a history and physical examination.
- Payment means activities pertaining to reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your treatment to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conduction quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. For example a quality assessment review to make sure the obstetrical or gynecological care you receive is of the highest quality.

YOUR RIGHTS

You have the following rights regarding your protected health information, which you can exercise by presenting a written request to our Privacy Officer:

- Right to inspect and copy your protected health information
- Right to amend your protected health information
- Right to receive an accounting of disclosures of your protected health information
- Right to request restrictions on certain uses and disclosures of protected health information. We are however, not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
- Right to request confidential communication from us by alternative means or at alternate locations
- Right to receive a paper copy of this notice upon request

CHANGES TO THIS NOTICE

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right - hand corner.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office manager or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing. You will not be penalized for filing a complaint. To make a request or file a complaint with our office contact:

Diana Holmgren, Clinic Director for Total Family Care
12350 Westheimer Road Suite G, Houston, TX 77077
281.496.1199 extension 104

A little bit about us.....

Address
12350 Westheimer Road Suite G, Houston, TX 77077
Phone | 281 - 496 - 1199
Fax| 281 - 496 - 1441
Hours
Monday - Friday 8:00-6:00
Saturday 9:00-1:00 (sick visits)
We will accept walk - in appointments if we have the availability

WE ARE NOW OFFERING PATIENT PORTAL

www.healthtracker.com

Total Family Care is pleased to announce that patients can now access their health records online. Our Patient Portal makes it easier for you to participate in managing your health care. Registration is simple... we will email you an invitation today and it will prompt you to create a username and password. Once your account is created you will be able to do the following:

1) Update your personal information 2) Review past appointments 3) Request new appointments

4) Request prescription renewals 5) View most of your test results

ALSO! We have the ability to communicate through **text message**. You can receive text message appointment confirmations, messages from your provider, and more. You may also text the phone number if you have a question for the receptionists.

IF YOU ARE HAVING ANY PROBLEMS ACCESSING EITHER OF THESE, PLEASE CONTACT US AT THE CLINIC. HAVE A WONDERFUL DAY!