Murdock Family
HEALTH & WELLNESS

WEIGHT LOSS CONSULT PATIENT INFORMATION

Name:_____ Date of Birth:_____ Age: _____ Sex: ☐ Female ☐ Male

Address:_____ City:_____ State:_____ Zip: _____

Phone:_____ Work Phone:_____ Email:_____

Emergency Contact Name:_____ Emergency Contact Phone:_____

How did you hear about this clinic?
☐ Social Media:_____ ☐ Referral:_____
☐ Internet Search ☐ Billboard/Ad ☐ Other:_____

What are your chief complaints and/or reasons for seeking weight loss management?

_____

_____

Please check if you are affected by, or have any of the following:

☐ Allergies	☐ Dizziness/Vertigo	☐ Insomnia/Sleep Disorder	☐ Tendonitis
☐ Asthma	☐ Fatigue/Low Energy	☐ Low/Depressed Mood	☐ Thyroid Disorder
☐ Auto-Immune Disease	☐ Headaches/Migraines	☐ Memory Loss/Alzheimer's	☐ Urinary/Kidney Issues
☐ Blood/Clotting Disorders	☐ Hormonal Imbalance	☐ Mental Fog	☐ Weight Issues
☐ Cardiac Issues	☐ IBS/Inflammatory Bowels	☐ Numbness/Tingling	☐ Other:_____
☐ Diabetes	☐ Immunosuppression	☐ Osteoprosis	_____

Please list all medications you are currently taking (including herbal, over the counter, topical, oral, and supplemental):

_____

_____

Are you currently: ☐ Pregnant ☐ Trying to get pregnant ☐ Breastfeeding ☐ Taking Birth Control
☐ Taking Antibiotics ☐ Experiencing An Active Infection

Do you have any allergies to foods or medications? ☐ Yes ☐ No **Allergies:** _____

Do you have allergies/sensitivities to: ☐ Alcohol-Based Products ☐ Cobalamin ☐ Cobalt ☐ Latex

Medical/Medication History:

Have You Ever Been Diagnosed With:
☐ Chronic Kidney Disease (CKD) ☐ Iron Defiency ☐ Megaloblastic Anemia
☐ Kidney Dysfunction ☐ Liver Disease/Cirrhosis
☐ Folic Acid Defiency ☐ Leber's Disease

Have you ever had a cardiac stent placement? ☐ Yes ☐ No ***If Yes:*** *Surgery Date:* _____

Are you receiving treatment or taking any medication that has an effect on bone marrow? ☐ Yes ☐ No

Do you currently take any of the following medications?
☐ Cobalt Irradiation ☐ Colestipol ☐ Metformin ☐ Proton Pump Inhibitors
☐ Metformin ER ☐ Glyburide ☐ Glipizide

I affirm the above information is accurate to the best of my knowledge. I acknolwedge that MURDOCK FAMILY HEALTH AND WELLNESS Staff are not responsible for any errors that may occur as a result of any omissions or incorrect information on this form.

Patient Name (Print) **Patient Signature** **Date**

2400 HWY 365 Suite 101
Nederland, TX 77627
409.724.600

Murdock Family
HEALTH & WELLNESS

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

_____ Protected health information may be disclosed or used for treatment, payment, or healthcare operations.

_____ The practice reserves the right to change the privacy policy as allowed by law.

_____ The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.

_____ The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

_____ The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO
May we leave a message on your answering machine at home or on your cell phone? YES NO
May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

Name: _____

Relationship: _____

This consent was signed by: _____ Date of Birth: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

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PATIENT TELEMEDICINE CONSENT

PATIENT NAME: _____ DOB: _____

1. I UNDERSTAND THAT MY HEALTHCARE PROVIDER WISHES ME TO ENGAGE IN A TELEMEDICINE CONSULTATION.
2. MY HEALTHCARE PROVIDER HAS EXPLAINED TO ME HOW THE VIDEO CONFERENCING TECHNOLOGY WILL BE USED TO AFFECT SUCH A CONSULTATION AND THAT IT WILL NOT BE THE SAME AS A DIRECT PATIENT/HEALTHCARE PROVIDER VISIT DUE TO THE FACT THAT I WILL NOT BE IN THE SAME ROOM AS MY HEALTHCARE PROVIDER.
3. I UNDERSTAND THERE ARE POTENTIAL RISKS TO THIS TECHNOLOGY, INCLUDING INTERRUPTIONS, UNAUTHORIZED ACCESS AND TECHNICAL DIFFICULTIES. I UNDERSTAND THAT MY HEALTHCARE PROVIDER OR I CAN DISCONTINUE THE TELEMEDICINE CONSULT IF IT IS FELT THAT THE VIDEOCONFERENCING CONNECTIONS ARE NOT ADEQUATE FOR THE SITUATION.
4. I HAVE HAD THE ALTERNATIVES TO A TELEMEDICINE CONSULTATION EXPLAINED TO ME, AND IN CHOOSING TO PARTICIPATE IN THE TELEMEDICINE CONSULT.

BY SIGNING THIS FORM, I CERTIFY:

1. THAT I HAVE READ OR HAD THIS FORM READ AND/OR THIS FORM EXPLAINED TO ME.
2. THAT I FULLY UNDERSTAND ITS CONTENTS INCLUDING THE RISKS AND BENEFITS OF THE PROCEDURE(S).
3. THAT I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND THAT ANY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION.

CONFIDENTIAL EMAIL:

_____ _____

SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN DATE:

MURDOCK FAMILY HEALTH AND WELLNESS

OFFICE POLICIES & PROCEDURES FOR OUR PATIENTS

Our goal is to provide quality medical care in a timely manner. In order to do so we have implemented an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care. Please feel free to contact our office if you have any questions regarding our policies.

OFFICE HOURS

Our office is available Monday-Friday 9:00am to 5:00pm, we are closed from 12:00 pm – 1:30 pm for lunch. If you need an appointment, prescription refill or test results, please call during regular business hours.

APPOINTMENTS

To ensure timely continued care, we encourage patients to schedule appointments in advance of follow up due dates. When calling for an appointment, please provide your name, telephone number, chief complaint/reason for visit, as well as any updated contact or insurance information. While we strive to schedule appointments appropriately, emergencies can and do occur in Primary Care. We strive to give all of our patients the time that they require. For this reason, we kindly request your patience and understanding should a delay or rescheduling become necessary on your appointment date. We encourage you to schedule appointments for preventative health visits, physicals, pap exams, chronic medical conditions, prescription renewals and sick visits.

CANCELLATION OF AN APPOINTMENT

In order to be respectful of the medical needs of our patients please be courteous and call Murdock Family Health and Wellness promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in need of treatment. This is how we can best serve the needs of our patients. If it is necessary to cancel your scheduled appointment we require that you call one (1) working day in advance. Appointments are in high demand, and your early cancellation will give another person the ability to have access to timely medical care.

NO SHOW POLICY

A “no show” is someone who misses an appointment without canceling it within one (1) business day in advance. No-shows inconvenience those individuals who need access to medical care in a timely manner. A failure to present at the time of a scheduled appointment will be recorded in your medical chart as a “no show”. An administrative fee of $25.00 will be billed to your account. You will be sent a Three (3) “no-shows” within one (1) calendar year will result in a temporary suspension of services. In

order to reinstate services, you will be required to meet with your Primary Care Physician within 30 days of the third no show letter to evaluate your situation. In the event you do not respond and/or schedule an appointment within 30 days, we will consider your patient status as terminated.

**Please note that No-Show charges are patient responsibility and will not be billed to your insurance company.

INSURANCE

Murdock Family Health and Wellness accepts most insurance plans. If you have specific questions regarding your insurance, please contact our billing department. It is patient responsibility to inform our office of any changes in insurance coverage. Failure to do so could cause delay or denial of insurance payment. Patients are responsible for co-pays at time of service. If applicable, you will be billed for services not covered by your insurance (as stated in your insurance contract) by our billing department.

PAYMENTS

Murdock Family Health and Wellness accepts cash, personal checks, MasterCard, Discover, Visa and American Express. Checks can be made out to Murdock Family Health. In the event of a return check, you will be responsible for the check amount + $35 return check fee. It is our policy to make all reasonable attempts to collect outstanding balances' should they accrue, including, convenient payment arrangements. Following these attempts, accounts in poor standing will be outsourced to a third party for the purpose of collection.

FORMS/LETTERS

We understand that at times, various forms or letters may be required to assist you with your healthcare needs. The staff at Murdock Family Health and Wellness will be happy to complete forms and write medical letters as necessary upon your request. The fee to fill these out outside of an office visit is $25. However, because this can be time consuming, please allow 3-5 business days for completion of requested forms/letters.

MEDICAL RECORDS

Per HIPAA guidelines, copies of medical records must be requested in writing. To ensure your privacy, a form for release of medical information must be completed prior to receipt of these materials. All patients can request a copy of their medical records for $25.00 for the first 20 pages and .50 cents for each additional page. The law allows Medical Offices 30 days to complete requests for records. However, our medical records department puts forth every effort to respond to these requests in a timely manner.

PRESCRIPTION REFILLS & PHARMACY INFORMATION

Please inform Murdock Family Health and Wellness of which Pharmacy you use and update us if this should change. Please allow one to two business days for refill requests. We encourage our patients to review their medications prior to their office appointments and to request refills at that time, if needed. Please note that we do not fill Narcotic Medications or order Antibiotics over the phone. Our Practice does not routinely order Narcotic Pain Medicine, therefore you may be required to obtain these medications through Pain Management.

MURDOCK FAMILY HEALTH AND WELLNESS

OFFICE POLICIES & PROCEDURES FOR OUR PATIENTS

RECEIPT ACKNOWLEDGMENT FORM

By signing below, I acknowledge that I have received, reviewed, understand, and will comply with the policies and procedures explained in the Murdock Family Health and Wellness OFFICE POLICIES & PROCEDURES FOR PATIENTS form.

_____

Printed Name

_____ _____

Signed Name Date

THANK YOU!

Murdock Family Health & Wellness