PATIENT INFORMATION FORM

Patient name: _____
LAST FIRST MIDDLE

Date of Birth: _____ Age: _____ (please circle :) Female Male

Address: _____ **Responsible Party SS#:** _____
Required If patient a minor and/or full-time student

City: _____ State: _____ Zip: _____

Home Phone # _____ Work/ Cell Phone # _____

Patient SS# _____ Drivers License # _____

Employer: _____ Occupation: _____

Employer's City: _____ State: _____ Zip: _____

Marital Status (please circle): Married Single Divorced Widowed

Name of Spouse: _____ Spouse's Work Phone # _____

Primary Insurance Company: _____ Name of Insured: _____

Relationship to Insured: _____ Insured's DOB: _____

Insured SS # _____ Group Name/Number: _____ Policy # _____

Secondary Ins: _____ **Name of Insured:** _____
SEVEN OAKS WILL ONLY BILL 2ND IF WE ARE CONTRACTED PROVIDER

SS# / Policy # of insured: _____ Insured's DOB: _____

Referring Physician: _____ Phone #: _____ Fax #: _____

Date of Injury/Start of Symptoms: _____ **Area of Body to be treated** _____
INSURANCE REQUIRES THE DATE, MONTH AND YEAR (WILL NOT PAY WITHOUT THIS INFORMATION)

Type of Accident/Illness: _____ No ____ Yes _____
(Home? Work? Sports? Auto?) Do you have an **Atty? If so, Name & Tel number**

I DO HEREBY ASSIGN all insurance benefits to be paid directly to MURDOCK FAMILY HEALTH AND WELLNESS for all medical services provided to me. I also acknowledge that I am personally liable for all charges incurred by me for treatment services provided me by MURDOCK FAMILY HEALTH AND WELLNESS. I AUTHORIZE MURDOCK FAMILY HEALTH AND WELLNESS to release information required regarding the course of my treaunent, for the purpose of evaluating and administering claims for benefits. I understand I am responsible for services not cover by my insurance, i.e. benefits exhausted or do not meet criteria of medical necessity per your plan's guidelines. **I have been informed of & agree to abide by the cancellation policy. ANY PERSONAL BALANCE 30 DAYS OR MORE PAST DUE MAY BE SUBJECT TO A 1.5% FINANCE CHARGE.**

_____ _____
SIGNATURE OF PATIENT / PARENT IF MINOR DATE

_____ _____
SIGNATURE OF RESPONSIBLE PARTY / PARENT IF PATIENT IS FT STUDENT DATE

History Form – Primary Care

What name do you like to be called?_____

What is the best number to reach you during the day? ( )_____-_____

May we leave a brief message? □ Yes □ No

Medical History: Have you ever been treated for any of the following medical conditions?

□ No changes
□ Arthritis
□ Diabetes
□ High blood pressure
□ Irritable bowel
□ Osteoporosis
□ Cancer
□ Depression/anxiety
□ Heart problems
□ High cholesterol
□ Lung problems
□ Thyroid problems

Please list any additional medical conditions:

_____

Have you ever been hospitalized overnight? □Yes □No

Have you ever had surgery? □ Yes □ No _____

_____

Medications and Allergies will be reviewed by clinic staff.
(Please bring your bottles with you or a complete list of everything you take on a regular basis.)

Do you take any supplements (calcium/vitamin D/fish oil/multivitamin)? □Yes □ No

Family History: Please list any known medical problems for the relatives listed below:

For example: diabetes, breast/colon/ovarian/ prostate cancer, heart attacks, high blood pressure, alcohol abuse, depression, skin cancer, osteoporosis.

□ No changes
Mother:_____
Father:_____
Brothers/Sisters:_____
Children:_____
Other:_____
_____
_____

Habits:

What do you do for exercise?_____
How often?_____
Tobacco (chew / smoke): _____per day
Alcohol (beer / wine, etc.):_____ per day
Street Drugs (marijuana, etc.):_____
Caffeine (coffee / tea / soda):_____ per day
Any trouble sleeping? □ Yes □ No
Describe your eating habits: (poor, well-balanced, vegetarian, gluten-free, etc.)_____
Do you eat out more than twice a week? □ Yes □ No

Social History:

Are you retired? □ Yes □ No
Work Type:_____
Do you enjoy your job?_____

Any major stresses in your life?
_____
_____
_____

Relationship Status:

□ Married □ Single □ Widowed
□ Divorced/Separated
□ In a relationship
How long?_____

Who do you live with:_____
How many children do you have?
_____
Do you feel you ever have been abused (verbally, physically, or sexually? □ Yes □ No

Do you wear seatbelts/helmets?
□ Yes □ No □ Sometimes

Do you wear sunscreen?
□ Yes □ No □ Sometimes

Do you have an eye exam at least every two years?
□ Yes □ No

Do you have a dental exam at least yearly? □ Yes □ No

Continue on back…..

REVIEW OF SYSTEMS

Please circle any current symptoms below:

General Symptoms:
Fever, unexplained tiredness, swollen glands, excessive thirst, feeling unusually hot or cold, easy bruising or bleeding, passing out

Eyes:
Vision loss, eye pain, blurred vision

Ears/Nose/Mouth & Throat:
Sore throat, runny nose, hearing loss, problems with mouth, voice changes

Breasts:
Lumps, skin changes, nipple discharge

Lungs & Heart:
Chest pain/pressure, irregular heart beat, cough, wheezing, breathing trouble

Skin:
Rashes, changing moles, changes in hair/skin/nails

Neurological:
Unusual or new headaches, weakness or numbness, falling

Abdomen:
Nausea, vomiting, pain, heartburn, diarrhea, constipation, bloody stools

Sleep:
Difficulty falling asleep, frequent awakening

Musculoskeletal:
Joint/muscle pain, muscle weakness

Mood:
Worry too much, felt down and depressed in the last two weeks, loss of desire to do things you used to enjoy, thoughts of self harm or suicide

Men Only:
Difficulty starting or weak stream, difficulty getting/maintaining erections, feeling like bladder won't empty, getting up at night to urinate, testicular pain/lumps, possible sexually transmitted infections

Women Only:
Heavy periods, bleeding after menopause, sexual concerns, unusual vaginal discharge, possible sexually transmitted infections, severe pain with periods, leaking urine

Period Questions:
Still having periods? □ Yes □ No
□ Regular □ Irregular
Date of last period:_____
Birth Control type:_____
Hysterectomy: □ Yes □ No
If yes, what age?_____
Due to what?_____
Number of pregnancies:_____
_____ Vaginal deliveries
_____ C-section deliveries
_____ Other (stillbirth, miscarriage/abortion)
Diabetes in pregnancy? □Yes □ No
Have you ever had an abnormal pap or colposcopy? □ Yes □ No

Other:
List any symptoms not mentioned:
_____
_____
_____

*******The following will be completed and used by clinic staff:*******

Prevention

Women:
Last Pap Test:_____
Chlamydia Screening:_____
Mammogram:_____
Bone Density:_____

Men:
PSA Screening:_____

Everyone:
Colonoscopy:_____
Lipid Panel:_____
Fasting Glucose_____ HgbA1c_____

Immunizations:
Tdap:_____ Zostavax:_____
Pneumovax:_____ Influenza:_____
Gardasil:_____

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: _____

Murdock Family
HEALTH & WELLNESS

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:

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____ **Date of Birth:**_____

Phone: H) _____ **Phone: W)** _____

Address: _____ **City/State/Zip:** _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ **Facility Phone:** _____

Facility Address:_____ **Facility Fax:**_____

City, ST, Zip: _____

Dates and Type of information to disclose:

☐ 2 years prior from last date seen
☐ Dates Other: _____
☐ Specific Information Requested:
_____

The purpose of disclosure is:

☐ Change of Insurance or Physician
☐ Continuation of Care (e.g., VA Med Ctr)
☐ Referral
☐ Other_____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: _____

Address: _____

City, State, Zip: _____ ☐ **Please mail records.**

Fax: _____ **Phone:** _____ ☐ **Please fax records.**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative **Date**
(Guardian or Authorized Representative must attach documentation of such status.)

_____ _____

Printed name of Authorized Representative Relationship / Capacity to patient

_____

Address and telephone number of authorized representative

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