Patient information

Patient name (first, middle, last): _____

Address: _____

City:_____ State: _____ ZIP: _____ Email: _____

Main phone: _____ Other phone:_____ Work phone: _____

Date of birth: _____/_____/_____ ○ Male ○ Female ○ Other

Relationship status: ○ Single ○ Married ○ Partnered ○ Divorced ○ Widowed

Patient referred by: _____

Emergency contact name:_____ Relationship: _____ Phone: _____

Primary care doctor: _____ Phone:_____

Referring doctor: _____ Phone:_____

Other patient information

Which race do you identify with?

○ African American ○ Asian ○ Caucasian ○ Hispanic

○ Native American ○ Native Hawaiian ○ Pacific Islander ○ Other: _____

What's your ethnicity? ○ Hispanic or Latino ○ Not Hispanic or Latino

What's your preferred language? ○ English ○ Spanish ○ Other: _____

Health insurance information

Primary health insurance:_____ Policy or ID number: _____

Name of policy holder: _____

Date of birth: _____/_____/_____ Group or account number: _____

Employer: _____ Employer address: _____

City: _____ State: _____ ZIP: _____ Work phone: _____

Secondary health insurance (if any): _____ Policy or ID number: _____

Name of policy holder: _____

Date of birth: _____/_____/_____ Group or account number: _____

Employer: _____ Employer address: _____

City: _____ State: _____ ZIP: _____ Work phone: _____

Fill out this section if patient is a minor

Parent or guardian name: _____ Relationship: _____

Parent or guardian name: _____ Relationship: _____

List any brothers or sisters with date(s) of birth: _____

General consent form

Patient name:_____ **Date of birth:**_____/_____/ _____

Assignment of benefits. I authorize USMD Physician Services, ("USMD") to submit claims on my behalf directly to Medicare/Medicaid/my private health insurance carrier. This means that USMD will collect payment for supplies and services provided. I understand that I am financially responsible to the provider(s) for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims. This assignment will remain in effect until revoked by me in writing.

Patient initials: _____

Consent for treatment. I consent for USMD to administer treatments, tests and/or diagnostic tests to treat my/the patient's injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives. In compliance with state law, if another individual is accidentally exposed to my/the patient's blood or body fluids (BBF); or if a medical or surgical procedure could expose another individual to my/the patient's BBF, USMD may have such BBF tested for human immunodeficiency infection (HIV/AIDS) at USMD's expense.

Patient initials: _____

Electronic prescription. I understand USMD utilizes electronic prescribing technology and participates with SureScripts. SureScripts operates the Pharmacy Health Information Exchange, which facilitates the electronic transmission of prescription information between providers and pharmacists. SureScripts also provides prescription data on any medications, known as medication history, which are prescribed to me/the patient.

Phone calls. By providing contact information, I authorize USMD, its assignees, and third party collection agents to use the contact information I have provided to communicate with me and to place calls to my home/cellular/employment telephone; leave voice or text messages; and use pre-recorded/artificial/voice messages and/or auto-dialing devices in connection with any communication to me.

Involvement of others in care. I authorize USMD to discuss my/the patient's care and medical needs with the following persons:

Name	Date of birth (for identification)	Relationship	Phone number

☐ I DO NOT wish to add an additional contact to discuss my/the patient's needs. **Patient initials:** _____

May we contact you by phone and leave a message about your care?

Primary phone number:_____ Secondary phone number: _____

☐ Leave message with contact number only.
☐ Leave message with detailed information.
☐ Do not leave message.

☐ Leave message with contact number only.
☐ Leave message with detailed information.
☐ Do not leave message.

Patient financial policy

I acknowledge receipt of the "Patient Financial Policy." **Patient initials:** _____

Notice of privacy practices

I acknowledge receipt of the "Notice of Privacy Practices." **Patient initials:** _____

Notice of telehealth/telemedicine services

I acknowledge receipt of the "Notice of Telehealth/Telemedicine Services." **Patient initials:** _____

Minor patient photograph (when applicable)

I consent for USMD to photograph the minor patient for identification purposes only. **Patient initials:** _____

Print name of patient or personal representative | Signature of patient or personal representative | Date

Financial policy

Please read prior to receiving services.

USMD Physician Services ("USMD") recognizes the need for a clear understanding between patient and medical provider regarding protected health information and financial arrangements for healthcare. The following information is provided to avoid any misunderstanding concerning protected health information and payment for professional services.

- **PAYMENT: Payment is expected at the time of service.** If your deductible has not been met, or a percentage is your responsibility, we expect payment when services are rendered. **Even though insurance will be filed, you are responsible for any balance after insurance processes your claim.** All charges for treatment become due and payable sixty (60) days after the date of service. These periods allow sufficient time to process insurance and make payment in full of any remaining balance. There will be a $25 charge for returned checks. If not paid within 60 days, USMD will begin various collection activities including, but not limited by submitting the past due account to a collection agency.

- **SELF PAYMENT (PRIVATE, CASH PAYMENT):** If you have no insurance coverage we ask that you coordinate your care with our business office prior to your visit. We require an advance payment for professional services.

- **MANAGED CARE: All managed care (HMO, PPO, etc.) co-payment amounts are due at the time of service.** If your insurance plan requires a referral authorization from a primary care physician please present this at your initial visit. If you request an office visit or surgery without a referral authorization your insurance plan may deem this as **"out of network" or "non covered" treatment**, and you will be responsible for a larger amount or all of the charges. The patient acknowledges that it is the patient's responsibility to be aware of what services are covered and agrees to pay for any service deemed to be non covered or not authorized by the plan.

- **MEDICARE:** USMD providers are participating providers with the Medicare program and accept as payment, the Medicare allowable, patient deductible and/or 20% co-insurance. If you have supplemental insurance (Medigap) to cover the portion of the charges that Medicare does not pay, please provide us with a copy of your insurance card and any forms your insurance company may require. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. In this rare case you may be asked to sign a waiver form, which states that you understand that you will be responsible for these charges.

- **AUTOMOBILE ACCIDENT PATIENTS:** We do treat automobile accident patients. However, we are unable to monitor long-term accounts and require payment as a self-paying patient. We will not accept a letter of protection from an attorney as a guarantee of payment or third party insurance payments.

- **CHILDREN OF DIVORCED PARENTS:** Responsibility for payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks the treatment. Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of USMD.

- **SECONDARY INSURANCE:** The Texas Department of Insurance requires the patient to provide secondary insurance coverage to the provider if applicable. Patient agrees to provide such information. Patient agrees to immediately notify provider of any future additions, changes or deletions in primary or secondary insurance coverage.

Financial policy

- **PROMPT PAYMENT DISCOUNTS:** USMD offers a prompt payment discount to patients who do not have insurance and who pay in full at or before the time of service. Prompt payment discounts cannot be applied to co-pays or deductibles. Patients paying at the time of visit should be aware that additional charges related to the visit may be billed at a later time.

- We offer the opportunity to establish a reasonable payment plan if you are not able to pay in full at the time of service. If you have an outstanding balance, we expect you to make payment or payment arrangements before your next scheduled appointment. Non-payment may result in discharge from the practice.

- If you have **Medicaid** coverage of any kind, you must notify us prior to your visit. This is part of your agreement with Medicaid, and **failure to notify us** of Medicaid coverage will result in full financial responsibility for services rendered.

- Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our primary care physician is listed as your primary care provider with your insurance company, if required by your contract with your insurance company. In the event we are not participating providers or our physician is not listed as your primary care provider with your insurance company, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service.

- We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30 days after receipt of the initial statement. You can call **(817) 514-5200**.

- Repeat no shows or cancellations within 24 hours could result in discharge from the clinic.

- **Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

USMD firmly believes that a good patient/physician relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide the highest quality care to our patients. If you have any questions or need clarification regarding these policies please call us at (817) 514-5200.

Notice of Telehealth/Telemedicine Services

Please read prior to receiving services.

I understand that I have the following rights with respect to telehealth/telemedicine:

1. Definition of telehealth/telemedicine. Telehealth/telemedicine services involve the use of secure interactive videoconferencing equipment and devices or platforms that enable health care providers to deliver healthcare services to patients when located at different sites.

2. Right to care. I understand that the same standard of care that applies to an in-person visit will apply to a telemedicine/telehealth visit. I understand that I have the right not to participate or decide to stop participating in a telehealth/telemedicine visit and that my refusal will not affect my ability to seek care or treatment in the future.

3. Patient information & confidentiality. I understand that the laws that protect the privacy and the confidentiality of health care information also apply to telehealth/telemedicine services. I understand that I have a right to access my medical information in accordance with federal and state law. I understand that my insurance carrier will have access to my medical information for quality review and/or audit purposes. I understand that I will not be physically in the same room as my clinician and I will be notified of and my consent obtained for anyone other than my clinician present. I understand that the release of my medical information, to include audio and/or video, may be by electronic transmission.

4. Communication risk & consent. I understand that there are potential risks with using telehealth and video technology, including, but not limited to, the possibility, despite reasonable efforts on the part of my provider, interception, interruption, or distortion due to technical failures. If it is determined that the electronic connection is not adequate, I understand that my health care provider or I may discontinue use and make other arrangements to continue the visit by other methods. I understand that my consent will be obtained to receive SMS messages to my mobile device according to the Texting Terms and Conditions available at www.usmd.com/texting-terms.

5. Insurance & Billing. I agree and understand that I am responsible for any out-of-pocket costs, including deductibles, copayments, or coinsurances, that apply to my telehealth/telemedicine visit. I understand that health plan payment policies for telehealth/telemedicine may differ from in-person visits.

I acknowledge that I have read this document or have had it read to me, that I have asked for clarification on any part of this document that I do not understand, and that I understand its contents.

USMD firmly believes that a good patient/physician relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide the highest quality care to our patients. If you have any questions or need clarification regarding these policies, please call us at (817) 514-5200.

New patient medical history form

DATE TODAY: _____

NAME: _____ _____ _____ **D.O.B.** ____/____/_____
LAST FIRST M.I.

OCCUPATION: _____

REASON FOR VISIT TODAY: _____

_____

ALLERGIES (Include medications, foods, xray dyes) or ☐ **NONE KNOWN**

Name of allergen	Type of reaction	Approximate date
1		
2		
3		

CURRENT MEDICATIONS (Include prescription, over the counter, and herbal medications. Attach extra sheet if necessary) or ☐ **NONE**

Name of medication	Dose (mg)	How often taken	Reason for taking medication	Doctor prescribing
1				
2				
3				

PHARMACY (list pharmacy most frequently used for prescriptions)

Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State/ZIP: _____

PREVIOUS HOSPITALIZATIONS (Include all non surgical hospitalizations. Attach extra sheet if necessary) or ☐ **NONE**

Reasons for hospital stay	Date (approximate)	Hospital or city if known
1		
2		
3		

SURGERIES (Include all surgery in your lifetime. Attach extra sheet if necessary) or ☐ **NONE**

Type of surgery	Date (approximate)	Hospital or city if known
1		
2		
3		

OB/GYN HISTORY: Number of pregnancies: _____ Number of deliveries: _____ Last menstrual cycle: _____

TOBACCO HISTORY

Are you an active cigarette smoker? ☐ Yes ☐ No

Have you ever been a cigarette smoker? ☐ Yes ☐ No

If yes, I smoked an average of _____ packs per day for _____ years. I quit in _____(year)

Do you use other tobacco products? ☐ Yes ☐ No

If yes, please specify _____

ALCOHOL AND DRUG HISTORY

Have you ever been diagnosed with alcoholism? ☐ Yes ☐ No

Do you currently drink alcohol regularly? ☐ Yes, currently ☐ Never/rarely

If yes, approximately how many drinks per week (beer, wine, or liquor)_____

Have you ever used intravenous drugs? ☐ Yes ☐ No

FAMILY HISTORY

Is there a history in your family of:	Yes	No	Affected relative(s)
Heart attack			
Diabetes			
Prostate cancer			
Kidney cancer			
Kidney stones			
Other significant disease			

New patient medical history form

DATE TODAY: _____

NAME: _____ (LAST) _____ (FIRST) _____ (M.I.) **D.O.B.** ____/____/_____

Please check "X" the complaint(s) or ailment(s) that apply to you. If you are unsure, place a question mark (?)

General	Fatigue/tired	☐Yes	☐No
	Fever/chills	☐Yes	☐No
	Headache	☐Yes	☐No
	Weight loss	☐Yes	☐No
	Weight gain	☐Yes	☐No
	Other: _____		
Eyes	Difficulty seeing	☐Yes	☐No
	Other: _____		
Head, ears, nose, throat	Dry mouth	☐Yes	☐No
	Hearing problems	☐Yes	☐No
	Hoarseness	☐Yes	☐No
	Lumps/swelling in neck	☐Yes	☐No
	Sore throat	☐Yes	☐No
	Trouble swallowing	☐Yes	☐No
	Other: _____		
Cardiac (heart)	Chest pain	☐Yes	☐No
	Irregular heart beat	☐Yes	☐No
	Pain with walking	☐Yes	☐No
	Shortness of breath	☐Yes	☐No
	Swelling in feet/ankles	☐Yes	☐No
	Other: _____		
Nervous system	Dizziness	☐Yes	☐No
	Fainting	☐Yes	☐No
	Headache	☐Yes	☐No
	Memory loss	☐Yes	☐No
	Numbness	☐Yes	☐No
	Weakness	☐Yes	☐No
	Other: _____		
Respiratory (breathing)	Cough	☐Yes	☐No
	Shortness of breath	☐Yes	☐No
	Use of inhalers	☐Yes	☐No
	Wheezing	☐Yes	☐No
	Other: _____		
Gastro-Intestinal (digestive)	Abdominal pain	☐Yes	☐No
	Blood in stool	☐Yes	☐No
	Change in bowel habits	☐Yes	☐No
	Constipation	☐Yes	☐No
	Heartburn	☐Yes	☐No
	Loss of appetite	☐Yes	☐No
	Nausea	☐Yes	☐No
	Vomiting	☐Yes	☐No
	Other: _____		

Males only	Blood in urine	☐Yes	☐No
	Difficulty achieving erection	☐Yes	☐No
	Foul odor in urine	☐Yes	☐No
	Pain in testicles	☐Yes	☐No
	Trouble urinating	☐Yes	☐No
	Other: _____		
Females only	Breast discomfort	☐Yes	☐No
	Irregular bleeding	☐Yes	☐No
	Last menstrual cycle *Date:* _____		
	Painful intercourse	☐Yes	☐No
	Post menopausal bleeding	☐Yes	☐No
	Trouble urinating	☐Yes	☐No
	Vaginal discharge	☐Yes	☐No
Musculoskeletal			
	Back pain	☐Yes	☐No
	Joint pain	☐Yes	☐No
	Muscle pain	☐Yes	☐No
	Swelling	☐Yes	☐No
	Other: _____		
Skin, hair, nails	Bruising	☐Yes	☐No
	Hair loss	☐Yes	☐No
	Nail problems	☐Yes	☐No
	Rash	☐Yes	☐No
	Skin changes	☐Yes	☐No
	Other: _____		
Mental health	Anxiety	☐Yes	☐No
	Depression	☐Yes	☐No
	Difficulty sleeping/concentrating	☐Yes	☐No
	History of physical/mental abuse	☐Yes	☐No
	Mood swings	☐Yes	☐No
	Stress	☐Yes	☐No
	Suicidal	☐Yes	☐No
	Other: _____		

Recent tests/ Health maintenance (Give month/year of last exam in right column. Check left column if date is estimated.)

- ☐ Bone density: _____
- ☐ Colonoscopy: _____
- ☐ Diabetic foot exam: _____
- ☐ Eye exam: _____
- ☐ Mammogram: _____
- ☐ Pap smear: _____
- ☐ Physical: _____
- ☐ PSA: _____
- ☐ Tetanus shot: _____