Dear Valued Patient,

On behalf of the physicians, associate practitioners, nurses and staff of USMD Physician Services, I want to welcome you to our organization and thank you for choosing a USMD physician to care for you and/or your loved ones.

At USMD, our physicians put their patients' needs first. We are committed to providing you and your family with the highest-quality care and exceptional customer service. Our physicians are board certified and committed to promoting good health and guiding patients toward a healthy lifestyle.

With nearly 70 locations and more than 250 physicians and associate practitioners in just under 20 different specialties, USMD offers convenient locations all across the Dallas-Fort Worth metroplex to care for everyone in your family at every stage of life.

One of the unique features that USMD offers is NextMD for MCNT patients and Follow My Health for UANT patients. Through NextMD and Follow My Health, patients have communication with their physician's office through a protected, online portal. NextMD and Follow My Health also give patients the ability to access and review lab results and request appointments and prescription refills. Please talk with a staff member if you have questions or would like more information.

To learn more about USMD, please visit our website at www.usmd.com.

Again, thank you for choosing USMD for your healthcare needs.

Sincerely,

Richard C. Johnston MD, FACP
Chief Executive Officer and Chief Physician Officer
USMD Health System

USMD Health System

PATIENT INFORMATION

Patient's Name (First, Middle, Last): _____

Address: _____

City:_____ State:_____ Zip Code: _____ Email: _____

Main Contact#: _____ Alternate#:_____ Work#: _____

Date of Birth: _____/_____/_____ Sex: ○ Male ○ Female SS# (optional): _____

Marital Status : ○ Single ○ Married ○ Divorced ○ Widowed Occupation: _____

Patient Referred By: _____ Spouse's Name: _____

Spouse's Date of Birth: _____/_____/_____ Main Contact#: _____ Alternate#: _____

Emergency Contact:_____ Relationship: _____ Phone#: _____

Primary Care Physician: _____ Phone#:_____

Referring Physician: _____ Phone#:_____

Other Patient Information

Which racial category does the patient most closely identify with?

○ African American ○ Asian ○ Caucasian ○ Hispanic

○ Native American ○ Native Hawaiian ○ Pacific Islander ○ Other: _____(Please Specify)

Ethnicity: What is the patient's ethnicity? ○ Hispanic or Latino ○ Not Hispanic or Latino

What is the patient's language of preference? ○ English ○ Spanish ○ Other: _____(Please Specify)

Insurance Information

Primary Insurance:_____ Policy/ID# _____

Name of Policy Holder:_____ DOB: _____/_____/_____ Group/Acct #:_____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip Code: _____ Work #: _____

Secondary Insurance: _____ Policy/ID#: _____

Name of Policy Holder:_____ DOB: _____/_____/_____ Group/Acct #:_____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip Code: _____ Work #: _____

Complete – Only if Patient is a Minor

Parent/Guardian Name: _____ Relationship: _____

Parent/Guardian Name: _____ Relationship: _____

Siblings:_____ DOB: _____/_____/_____ Other Siblings:_____ DOB: _____/_____/_____

USMD Health System

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

☐ 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 #: _____ Secondary Phone #: _____

☐ 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:** _____

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

USMD Health System

FINANCIAL POLICY

Patient Name: _____ Patient Date of Birth:_____/_____/_____

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.

USMD Health System

FINANCIAL POLICY

- **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.

- **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**.

- We may charge you a "No Show" fee if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.

- **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.

USMD Health System

NEW PATIENT MEDICAL HISTORY FORM

DATE TODAY: _____

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

OCCUPATION: _____

REASON FOR VISIT TODAY: _____

_____

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

Name of medication	Dose (mg)	How often taken	Reason for taking medication	Physician prescribing
1				
2				
3.				
4.				
5.				
6.				
7.				
8.				

PHARMACY (list pharmacy most frequently used for prescriptions)

Name: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State/Zip: _____

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

Type of surgery	Date (approximate)	Hospital or city if known
1.		
2.		
3.		
4.		
5.		

MEDICATION ALLERGIES

☐ Tape ☐ Latex ☐ X-ray Dye ☐ Iodine ☐ Betadine ☐ None or unknown ☐ Other _____

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/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
Have you ever used recreational drugs? ☐ Yes ☐ No
If yes, what kind? _____

FAMILY HISTORY

Is there a history in your family of:	Yes	No	Affected relative(s)
Heart disease			
Stroke			
High blood pressure			
Diabetes			
Tuberculosis			
Other significant disease			

USMD Health System

NEW PATIENT MEDICAL HISTORY FORM

DATE TODAY: _____

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

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: _____		
Endo-crinology	Diabetes	☐Yes	☐No
	Thyroid	☐Yes	☐No
Eyes	Impaired Vision	☐Yes	☐No
	Other: _____		
Head Ears Nose Throat	Dry Mouth	☐Yes	☐No
	Hearing Problems	☐Yes	☐No
	Hoarseness	☐Yes	☐No
	Lumps/Swelling in Neck	☐Yes	☐No
	Neck Stiffness	☐Yes	☐No
	Sore Throat	☐Yes	☐No
	Trouble Swallowing	☐Yes	☐No
	Other: _____		
Cardiac (Heart)	Atrial Fibrillation	☐Yes	☐No
	Chest Pain	☐Yes	☐No
	Elevated Cholesterol	☐Yes	☐No
	High Blood Pressure	☐Yes	☐No
	Heart Disease	☐Yes	☐No
	Irregular Heart Beat	☐Yes	☐No
	Pain with Walking	☐Yes	☐No
	Shortness of Breath	☐Yes	☐No
	Swelling in Feet/Ankles	☐Yes	☐No
	Varicose Veins	☐Yes	☐No
	Other: _____		
Neuro	Dizziness	☐Yes	☐No
	Fainting	☐Yes	☐No
	Headache	☐Yes	☐No
	Memory Loss	☐Yes	☐No
	Numbness	☐Yes	☐No
	Weakness	☐Yes	☐No
	Other: _____		
Respiratory	COPD	☐Yes	☐No
	Cough	☐Yes	☐No
	Shortness of Breath	☐Yes	☐No
	Sleep Apnea	☐Yes	☐No
	Use of Inhalers	☐Yes	☐No
	Wheezing	☐Yes	☐No
	Other: _____		

Gastro-Intestinal	Abdominal Pain	☐Yes	☐No
	Blood in Stool	☐Yes	☐No
	Change in Bowel Habits	☐Yes	☐No
	Constipation	☐Yes	☐No
	Heartburn	☐Yes	☐No
	Hemorrhoids	☐Yes	☐No
	Loss of Appetite	☐Yes	☐No
	Nausea	☐Yes	☐No
	Vomiting	☐Yes	☐No
	Other: _____		
General Urology	Blood in Urine	☐Yes	☐No
	Difficulty Urinating	☐Yes	☐No
	Kidney Disease	☐Yes	☐No
	Males Only		
	Pain in Testicles/Groin	☐Yes	☐No
	Other: _____		
Females Only	Breast Discomfort	☐Yes	☐No
	Currently Pregnant	☐Yes	☐No
	Nipple Discharge	☐Yes	☐No
Musculoskeletal			
	Arthritis	☐Yes	☐No
	Back Pain	☐Yes	☐No
	Joint Pain	☐Yes	☐No
	Muscle Pain	☐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: _____
- ☐ Mammogram: _____
- ☐ Physical: _____

USMD Health System

HISTORY OF PRESENT ILLNESS

SECTION 1: **PATIENT INFORMATION**

Patient Name: _____ Date of Birth: _____/ _____ /_____

Primary Care Physician: _____ Surgeon/OB/Gyn: _____

What is the main reason for your visit? _____

SECTION 2: **PRESENT SYMPTOMS**

What is the approximate date when the symptoms started or you first became aware of the problem?

_____ /_____ / _____ or _____ ☐ days ☐ weeks ☐ months ☐ years ago
Date Number (Check One)

Describe any previous treatment (medicines, surgery, etc.) prior to this visit for the problem: _____

_____

_____

_____

Complete the following section if the reason for today's visit is for breast/gynecologic cancer:

Age at onset of menstrual cycles . . . . . _____

At what age was your first pregnancy? . . . . . _____

How many times have you been pregnant? . . . . . _____

Have you ever taken any oral contraceptives? ☐ Yes ☐ No. If yes, for how long? . . . . . _____

Are you still menstruating? . . . . . ☐ Yes ☐ No

If yes, when was your last menstrual cycle? . . . . . _____

If you are post-menopausal, did you ever take oral hormone replacement therapy? . . . . ☐ Yes ☐ No

If yes, how long did you take hormone replacement therapy? . . . . . _____

Is there any family history of breast or ovarian cancers? . . . . . ☐ Yes ☐ No

If yes, who? . . . . . _____

When was your last mammogram? _____ /_____ /_____

Where was it performed? _____

_____

USMD Health System

HISTORY OF PRESENT ILLNESS

Patient Name: _____ Date of Birth: _____/ _____ /_____

SECTION 3: **FAMILY HISTORY**

This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to you and your family. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: You, parents, brothers, sisters, sons, daughters, grandparents, grandchildren, aunts, uncles, nephews, nieces, half-siblings, first cousins, great-grandparents and great grandchildren.

Cancer		You – Age at Diagnosis	Parents/Siblings/ Children	Age at Diagnosis	Relatives on your Mother's Side	Age at Diagnosis	Relatives on your Father's Side	Age at Diagnosis
Breast Cancer (female or male)	☐ Yes ☐ No							
Ovarian Cancer (Peritoneal/Fallopian Tube)	☐ Yes ☐ No							
Uterine (Endometrial) Cancer	☐ Yes ☐ No							
Colon/Rectal Cancer	☐ Yes ☐ No							
10 or more lifetime Gastrointestinal Polyps (specify number)	☐ Yes ☐ No							
Other Cancers (Specify cancer type)	Among others, consider the following cancers: Melanoma, Pancreatic, Stomach (Gastric), Prostate, Brain, Kidney, Bladder, Small Bowel, Sarcoma, Thyroid							
	☐ Yes ☐ No							

Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No

Are you concerned about your personal and/or family history of cancer? ☐ Yes ☐ No

Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? ☐ Yes ☐ No

If so, please explain and include a copy of result if possible: _____

_____

_____

_____