Deerwood Family Practice, PLLC
16675 Huebner Rd., Blding 2 Ste 210
San Antonio, TX 78248 (210)492-4300

**Patient Demographics:**

First Middle Last

D/O/B Gender SSN Marital Status

Home Address City State Zip Code

Home Number Cell Number Work Number

E-mail

**Employer:**

Employer Occupation

**Emergency contact:**

Name/ Relationship

Home Number Cell Number Work Number

**Spouse / Parent / Legal Guardian Details**

Name Relationship SSN D/O/B

Home Number Cell Number Work Number

**Other Information:**

Language Race Ethnicity Religion

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**Previous Physicians:**

Name Phone Number

Name Phone Number

**Insurance Information:**

**Responsible Party (Primary Card Holder) Information**

Last First Middle

D/O/B Gender SSN Marital Status

Address (if different from patient) City State Zip Code

**Primary Insurance**

Insurance Company Policy # Date Issued Group #

**Secondary Insurance**

Insurance Company Policy # Date Issued Group #

**Guarantor if different than above:**

Name Address Phone #

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NAME_____ DOB _____

Are you allergic to any medications:

_____

Do you take any medications? Please include regular use of over-the-counter medications, vitamins and herbal supplements. Use back of page if necessary. Please place an * by medications needing refills.

Name Strength Instructions

_____

_____

_____

_____

Do you have any of the following medical problems or have been diagnosed with any in the past?

| | |
|---|---|
| □ Arrhythmia/Irregular Heartbeat | □ Kidney Stones |
| □ Urinary Incontinence | □ Blood Clot (DVT/ pulmonary embolism) |
| □ Congestive Heart Failure | □ Fracture- location: |
| □ Recurrent Bladder infections | □ Carotid Artery Stenosis |
| □ Pneumonia | □ COPD/Emphysema/chronic bronchitis |
| □ Meningitis | □ Coronary Artery disease/Heart Attack |
| □ Erectile Dysfunction | □ Chronic pain/Fibromyalgia |
| □ Diabetes | □ Crohn's/Ulcerative Colitis |
| □ Gallstones | □ Pancreatitis |
| □ ADD/ADHD | □ Eczema |
| □ GERD/Heartburn | □ Peptic Ulcer |
| □ Heart Murmur/Valvular Disease | □ Cancer: Type: |
| □ Osteoarthritis | □ Peripheral Vascular Disease (PAD) |
| □ Osteoporosis | □ Gout |
| □ Hepatitis | □ Renal Failure |
| □ Anemia | □ Enlarged BPH |
| □ Hyperlipidemia/High Cholesterol | □ Rheumatoid Arthritis/ Lupus |
| □ Hypertension | □ Asthma |
| □ Hypothyroidism | □ Sleep Apnea |
| □ Seizure Disorder | □ Alzheimer's/Dementia |
| □ Irritable Bowel | □ Stroke/TIA |
| □ Allergies | □ Headaches/Migraines |

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| For Women only (please only fill out what is applicable): |
|---|
| Age at First Period:_____Date of last menstrual cycle: _____ |
| Number of Pregnancies:_____Were the all successful deliveries? |
| If not please explain: _____ |
| Are you using birth control?_____If so, what? _____ |
| Date of last Pap smear:_____Results: _____ |
| Any abnormal Pap?_____if so, please explain: _____ |
| |
| Date of last Mammogram: Results: |
| Any abnormal Mammograms?_____if so, please explain: _____ |
| |

Colonoscopies (dates and results): _____

_____

Surgeries (dates and details): _____

_____

Please list medical problems in your family. If none or unknown, please list as well.

Father: _____

Mother: _____

Brother(s): (number of): _____

Sister(s): (number of): _____

Paternal Grandfather: _____

Paternal Grandmother: _____

Maternal Grandfather: _____

Maternal Grandmother: _____

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Please give us information about yourself:

Occupation:_____for how long? _____

Any occupational or health hazard exposure? _____

Marital Status: _____

Any domestic violence?_____Stress level at home: _____

Do you have an Advanced Directive or a Living Will? _____ If yes will you be providing a copy? _____

Do you Exercise:_____if yes, duration/frequency: _____

Do you maintain a healthy diet? _____

Have you been on a diet within the last year? _____

Do you consume caffeinated drinks?_____how much per day? _____

Rank your fat intake:_____Rank your salt intake: _____

How often do you miss meals? _____or, Overeat? _____

Are you sexually active?_____any problems with your sex life? _____

Do you Drink alcohol?_____If yes, what type?_____amount? _____

If prior use, when did you quit?_____years of use? _____

Do you or did you use tobacco products? _____

If so what type?_____How much daily/week? _____

When did you start?_____For prior use, when did you quit? _____

Have you ever used any illegal or illicit drugs? _____

Local Pharmacy:

_____

Name Address Phone

Mail Order Pharmacy:

_____

Name Address Phone

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# Important Information on Preventative Care Benefits

Due to insurance regulations, all physicals, well-woman exams and well-child exams are considered preventative care visits. **Most** insurance companies cover 100% of one preventive care visit per year, however Deerwood Family Practice will not be responsible for any exclusions to your individual plan. Please check with your plan administrator with any questions or concerns. The visits cover general check-ups, routine cancer screenings, immunizations, counseling on diet and exercise, child development and vitamin supplements. Unfortunately, insurance companies will not cover **non**-preventative care issues raised during a preventative care visit. As such, we strongly encourage you to make a separate, follow-up appointment with our providers if you have medical concerns that fall outside of preventative care.

This will prevent your insurance company from billing you extra for your preventative care visit while ensuring our doctors schedule the appropriate amount of time to address your medical concerns. We thank you for your understanding in this matter.

Print name_____

_____ _____

Patient/Guardian Signature

Date of Birth_____/_____/_____

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# OFFICE POLICIES

CANCELLATIONS: We require at least a 24 hour notice for cancellation of appointments so that we may offer your appointment time to another patient. If you do not provide at least a 24 hour notice, you will receive a bill for the $65 NO-SHOW FEE.

TARDINESS: If you are 15 minutes late or more, you may be rescheduled in order to accommodate our other patients' appointment slots.

PRESCRIPTION REFILLS: Refill requests must be made at least one week in advance and should be faxed from your pharmacy to our office 210-492-4380.

NARCOTICS / CONTROLLED SUBSTANCES: Narcotics are carefully regulated medications and are generally not prescribed unless absolutely necessary. The providers at Deerwood Family Practice not only limit the use of narcotic prescriptions, but also want the patients prescribed narcotics to understand that if a patient reports the prescription was lost, a replacement prescription will not be issued. A limited number of narcotic medications will be prescribed. When the narcotic course is completed, the patient will be required to schedule an office visit and be seen by the provider. Narcotics refills will not be authorized without an office visit. Patients should be very careful with the prescription, treating it as one would cash. A drug screening is required before narcotics are prescribed.

AFTER HOUR CALLS: After-hours calls will be answered by our automated service. In case of an urgent matter that cannot wait for the next business day, you may reach the on-call provider. There will be a $25.00 fee for afterhour's consultations. We will not call in new prescriptions or refill prescriptions after hours. Please make prescription refills and appointment requests during regular office hours.

MEDICAL RECORDS: There is a $25.00 fee for release of medical records. This must be paid prior to the release of records as it helps cover the cost of printing and shipping. Please allow one week to process your request.

COMPLETION OF FORMS: As per the rules adopted by the State Board of Medical Examiners, our office will respond to the requests for the completion of medical forms following the receipt of the appropriate fees. Forms will be completed within five business days. Fees for forms are as follows: FMLA $50.00, HANDICAP Placard $5.00, DISABILITY $25.00.

DRUG SCREENING: *All* patients are subject to a random drug screening as determined by your provider.

I have read and understand the policies set forth by Deerwood Family Practice.

_____ _____

Patient/Legal Guardian Date

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_____ _____

**Patient Name** **Date of Birth**

# RELEASE OF PERSONAL HEALTH INFORMATION

I direct Deerwood Family Practice to disclose and release my protected health information Described below upon request to:

| Name | Relationship |
|---|---|
| | |
| | |
| | |
| | |
| | |

- ☐ Entire Record
- ☐ Radiology Reports
- ☐ Office Notes
- ☐ Immunization record
- ☐ Lab results
- ☐ Alcohol/substance abuse
- ☐ HIV/STD record
- ☐ Mental Health
- ☐ Billing

This authorization shall apply to all past, present and future periods and shall remain in effect unless revoked in writing.

_____ _____
Patient name/parent or guardian if minor Date

_____ _____
Patient name/parent or guardian if minor Date

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# *Lab Draw Consent*

Deerwood Family Practice cannot guarantee nor do we obtain prior authorization for any blood draws/specimen handling or processing. It is the patient's responsibility to know what labs or tests are covered by their insurance. If you have any questions regarding your coverage for blood draws and lab processing, please call your insurance prior to your appointment to verify that it is a covered service under your plan. Self-Pay patients must be aware that the fee for labs drawn will be collected at the time of the draw.

Due to numerous laboratories and the contract requirements of each, it is impossible to be affiliated with them all. Deerwood Family Practice is affiliated with *Accu Reference Laboratory*, *Singulex now Veridia & Avanti Laboratories (for Urine drug screens).* All blood drawn and specimens obtained *here* will be processed, analyzed and billed through one of these entities.

Blood draws with proper physician orders are welcome to have testing off site at their insurance specified lab of choice.

By signing below you acknowledge and accept responsibility if these labs are out of network; and that Deerwood Family Practice will NOT be responsible for any denied claims and the patient will be billed for services that are not covered by their insurance.

_____ _____

Signature of Patient/Responsible Party Date signed

_____ _____

Print Name Date of Birth

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# Patient Consent for use of Protected Health Information and Notice of Privacy Practices

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I have a right to request a copy of the Notice of Privacy Practices prior to signing this consent. A copy of will be provided to me by Deerwood Family Practice, PLLC upon request, in person, by phone or on our website at www.deerwoodfamilypractice.com.

I understand that Deerwood Family Practice, PLLC may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

My signature below indicates that I have been given the chance to review such copy of the Notice of Privacy Practices. My signature means that I agree to allow Deerwood Family Practice, PLLC to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Deerwood Family Practice, PLLC, has taken action relying on this consent

X _____

Print name of Patient/Legal Guardian ...

X _____

Signature of Patient/Legal Guardian ...

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# Authorization to Obtain Medical Records

## I authorize the following Physician's Office/Institution to release Medical Information on the patient listed below:

**Patient Name** **DOB** **Social Security #**

| |
|---|
| Previous Physician/ Institution Name |
| Phone # |
| Fax # |

To release health information to:

**Deerwood Family Practice, PLLC**
**16675 Huebner Rd., Building 2 Suite 210**
**San Antonio, TX 78248**

- ☐ Entire Record
- ☐ Radiology Reports
- ☐ Office Notes
- ☐ Immunization record
- ☐ Lab results
- ☐ Alcohol/substance abuse
- ☐ HIV/STD record
- ☐ Mental Health
- ☐ Billing

X

Patient/Legal Guardian Date

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Dear Patient,

Deerwood Family Practice requires a credit or debit card on file with our office.

Deerwood Family Practice will verify benefits, estimate patient portion and file all insurance documents. *However, it is the patient's responsibility to understand their coverage and that that there is no guarantee of payment from any insurance company. Your contract is with your insurance company.* We do our best to estimate what each insurance will pay but it is nearly impossible to be exact and at times the patient is left with a balance. The *majority* of the time the balance is less than $100.00.

How will I know how much you are going to charge me?
You will receive a letter in the mail from your insurance carrier that explains how much of your office visit they pay. This is called an Explanation of Benefits (EOB). This letter tells you exactly, according to your insurance coverage, how much they have paid. If your balance after insurance pays exceeds $100, we will charge the first $100 and notify you of the remaining balance. If paid more than expected, we will issue you a refund.

But wait, I'm nervous about leaving you my credit card.
We do not store your sensitive credit card information in our office. We store it on a secure website called a gateway. We access your information on this site only to process a payment. Unlike some retail stores that have been featured in the news recently for data breaches due to skimping on protective technology, we follow the Payment Card Industry Data Security Standards to the letter and will not compromise your data security. Medical practices are used to having to secure information under HIPAA laws, and we already have policies in place for any credit card information we come into contact with. We use Retriever Medical/Dental Payments, Inc. and all of our transactions are processed through Practice Management BRIDGE®. For more data visit http://www.retrievermed.com/distinctions/secure-processing/
Keeping the patient's card on file, offsite, in an encrypted payment gateway enhances security because there are fewer human touches in the process that can invite fraud. With a credit card on file system, after the initial swipe, the patient doesn't even have to bring the card to the visit.

What if I don't want to leave a credit card on file or I don't have a credit card?
This is not a problem. You can pay for your services as Self Pay today and we will file your insurance claim for you. We will have the insurance company reimburse YOU. In the event, they erroneously send us the check we will promptly refund you.

No Show and Cancellations for appointments
No Show and cancellations for appointments with less than 24 hours' notice will incur a fee of $65.00. When a patient fails to show up for an appointment or cancels last minute this prevents other patients from having that time and affects the quality of care we can offer to all patients. These will be charged to the card on file.

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Please choose one of the following options:
Options: Check box and initial next to the preferred option

- ☐ I opt to pay in full today and not leave a credit card on file. I agree to promptly pay any no show or cancellation fees within 10 days of occurring. Any overpayment by your insurance company after your claim has been filed will be left as a credit balance on your account at Deerwood Family Practice and can be used for future services provided._____

- ☐ I authorize Deerwood Family Practice to charge my credit card ending in _____, CVV code_____ for any remaining balance after my insurance has paid, not to exceed $100 as well as any no show or cancellation fees. If my balance exceeds $100 the first $100 will be charged and I will be sent <u>one statement</u> of any remaining balance and agree to pay within 30 days after being notified._____

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This agreement is in effect as long as I use insurance. I also understand that if my credit card is declined and/or my balance is not paid within 30 days from the date insurance pays, I will pay in full for future visits and have my insurance reimburse me. I will notify Deerwood Family Practice promptly if my credit card number changes or expires.

Patient Name: _____ Date: _____

Patient Signature: _____