

Registration Form:

Which Provider have you selected as your PCP? (please circle)

- Dr. J. Gabriel Dr. J. Bartos
- Dr. J. Lambert
- Dr. G. Fuller Dr. E. Swegler
- Dr. P. Henderson Dr. M. Kurz

Date: _____
Patient Name: _____
Address: _____

Home Phone: () _____ Work Number: () _____
Cell Phone: () _____
Occupation: _____ Employer: _____
Social Security: _____ D.O.B. : _____
Marital Status: _____ Sex(M/F): _____ Age: _____

If you have Health Insurance please indicate name below:

Primary Insurance: _____
Named of Insured/Guarantor: _____
Relationship to PT: _____ Social Security: _____
Policy Number: _____ D.O.B. : _____
Home Phone: () _____ Work Number: () _____
Name of Employer: _____
Secondary Insurance: _____
Named of Insured/Guarantor: _____
Relationship to PT: _____ Social Security: _____
Policy Number: _____ D.O.B. : _____
Home Phone: () _____ Work Number: () _____
Name of Employer: _____

Notice: Payment is due at the time of service.

I hereby authorize the release of any Medicare, medical and non-medical information necessary to process my medical claims and I request payment of insurance benefits to North Hills Family Medicine for all services rendered at this Clinic. I also understand that any fees incurred at North Hills Family Medicine which are not covered by my insurance company are my financial responsibility. I agree to provide North Hills Family Medicine with current insurance information that is necessary to file any claims for services or procedures performed. I understand that failure to do so will result in the charges being my financial responsibility. I also consent, voluntarily, to be a patient and receive medical treatment at North Hills Family Medicine. My signature below represents I have read the above and understand it.

Name: _____ Date: _____
Please circle one: Self Spouse Parent Grandparent Other

* **This section for Doctor's use only.**

* Allergies: _____

* **PMH & Long term problems:**

Past Surgical History

Family History

* Misc: _____

Social History

* ETOH _____ TOB _____

* Substance Use _____

NOTICE OF PRIVACY POLICIES AND PRACTICES

for

NORTH HILLS FAMILY MEDICINE

DEAR PATIENT:

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

At North Hills Family Medicine (NHFM), we are committed to treating and using protected health information about you responsibly. This Notice describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR MEDICAL RECORD/HEALTH INFORMATION

Each time you visit NHFM; a record of your visit is made. Typically, this record contains information about your visit including your examination, diagnosis, test results, treatment as well as other pertinent healthcare data. This information, often referred to as your health or medical record, serves as a:

- o Basis for planning your care and treatment
- o Means of communication with other health professionals involved in your care
- o Legal document outlining and describing the care you received
- o A tool that you, or another payer (your insurance company) will use to verify that services billed were actually provided
- o An education tool for medical health providers
- o Basis for public health officials who might use this information to assess and/or improve state as well as national healthcare standards
- o A tool that we can reference to ensure the highest quality of care and patient satisfaction

Understanding what is in your record and how your health information is used helps you to ensure it's accuracy, determine what entities have access to your health information, and make an informed decision when authorizing the disclosure of this information to other individuals.

YOUR RIGHTS

You have certain rights under the federal privacy standards. These include:

- o The right to request restrictions on the use and disclosure of your protected health information; must be in writing
- o The right to receive confidential communications concerning your medical condition and treatment
- o The right to inspect and copy your protected health information
- o The right to amend or submit corrections to your protected health information
- o The right to receive a printed copy of this notice

OUR RESPONSIBILITIES

NHFM is required to:

- o Maintain the privacy of your health information
- o We are required by law to provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- o Abide by the terms of this notice
- o Notify you if we are unable to agree to a requested restriction and acknowledge revisions with notifications
- o Accommodate reasonable requests you may have regarding communication of health information via alternative means and/locations

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Any updates will be posted in our office. We will not use or disclose your health information without your authorization, except as described in this notice.

HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION

We will use your health information for treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example: results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

We will use your information for payment. Your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated in order to pay for the service rendered to you.

We will use your information for regular health operations. Your health information may be used as necessary to support the day-to-day activities and management of NHFM. For example: information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Business Associates. In some instances, we have contracted separate entities to provide services to us. These "associates" require your health information in order to accomplish the tasks that we ask them to provide. Some examples of these "business associates" might be a collection agency, answering service and computer software/hardware provider.

Communication with family. Due to the nature of our field, we will use our best judgment (ex: emergency situations) when disclosing health information to a family member, other relatives, or any other person that is involved in your care or that you have authorized to receive this information. We will ask patients 18 years and older to sign a consent to release information to anyone other than themselves.

Healthcare Oversight. Federal law requires us to release your information to an appropriate health oversight agency, public health authority or attorney, or other federal/state appointee if there are circumstances that require us to do so.

Public health reporting. Your health information may be disclosed to public health agencies as required by law.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Appointment reminders. This practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are sent by mail or a brief, non-specific message may be left on your answering machine / voicemail.

Other uses and disclosures. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have complaints, questions or would like additional information regarding this notice or the privacy practices of NHFM, please contact:

Beverly Lovell, Privacy Officer
North Hills Family Medicine
4351 Booth Calloway Rd, Suite 101
North Richland Hills, TX 76180
817-284-1165

If you believe that your privacy rights have been violated, please contact the aforementioned practice Privacy Official, or, you may file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the practice's Privacy Official or with the Office for Civil Rights. The address for the Office for Civil Rights is listed below:

OFFICE FOR CIVIL RIGHTS
U. S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D. C. 20201

NORTH HILLS FAMILY MEDICINE FINANCIAL POLICY AND PATIENT CONSENT FORM

North Hills Family Medicine, PA ("NHFM") 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.

Please read our Financial Policy and Patient Consent Form and initial where indicated.

(initial) **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. This period allows sufficient time to process insurance and make payment in full of any remaining balance.

(initial) **SAME DAY PAYMENT DISCOUNT:** We offer a discount to any patient, who does not have insurance, paying for services in full at the time of the visit. This discount applies a 25% discount on the office visit only (any deductibles, co-insurances, labs, x-rays or other services will not be discounted). If payment in full is not made at the time of service or there is an outstanding balance on the account you will not be eligible for this discount

(initial) **CO-PAYMENTS: All managed care (HMO, PPO, etc) co-payment amounts are due in full at the time of service. You will be charged a \$10 billing fee if you do not pay your Co-Payment on the day of your visit.** For your convenience we accept cash, check, Visa, MasterCard, Discover and American Express.

(initial) **CANCELLED APPOINTMENTS:** If you are scheduled for an appointment that is not for an acute illness (i.e., cold, flu, injury, etc.) and are unable to keep your scheduled appointment, please call our office no later than 24 hours prior to your appointment time to reschedule your appointment. **NHFM will charge a \$25 fee for failure to keep these appointments. This fee will not be covered by your insurance and you will be required to pay this in full. A third no show may result in dismissal from the practice.**

(initial) **ROUTINE EXAMS:** Many insurance companies cover your yearly physical/well woman exam at 100% with no copay. Commonly, patients wish to discuss additional medical problems during their physical exam, when this occurs, further evaluation and treatment becomes necessary. In lieu of having you schedule another appointment, our providers will often manage your problem(s) at this time. This includes addressing ongoing medical conditions such as hypertension, diabetes, high cholesterol, and depression just to name a few. Discussion of these medical issues at the same time as your routine visit may be viewed by your insurance carrier as an additional encounter. **This additional encounter may be subject to your usual office visit charge or copay.**

(initial) **PATIENT RESPONSIBILITY:** We participate in many insurance plans. It is your responsibility to become familiar with your insurance benefits and confirm our participation with your plan. Please contact your insurance company with any questions you may have regarding your coverage. If the services you receive are not covered by your insurance you will be responsible for all of the charges for the visit. **Your initials indicate your understanding that it is your responsibility to be aware of what services are covered and that, further, you agree to pay for any service(s) deemed to be non-covered or not authorized by the plan.**

(initial) **DELINQUENT PAYMENTS: Effective January 1, 2011 if payment is not received in full on your balance within 60 days of the date on which it becomes due, you will be charged a collection fee of \$25 to cover the costs associated with collecting such balances. Additionally any checks returned for non-sufficient funds will be assessed a fee of \$25.**

**NORTH HILLS FAMILY MEDICINE
FINANCIAL POLICY AND PATIENT CONSENT FORM**

PROOF OF INSURANCE: Please bring your current, valid insurance card and a photo ID with you to every visit. We must obtain a copy of your insurance card and photo ID at the time of your visit. If we are unable to verify your current insurance information you will be required to pay the visit in full at the time of service.

MEDICARE: The physicians at NHFM are participating providers with the Medicare program and accept as payment the patient Medicare allowable, your 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. Medicare or secondary payers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. In the case of a non-covered service you may be asked to sign a waiver form, which states that you understand that you will be responsible for these charges. **EFFECTIVE JANUARY 1, 2011: The physicians of North Hills Family Medicine are not in-network providers with any Medicare Advantage Plan. We regret that we can only accept traditional Medicare Part B.**

CLAIMS SUBMISSION: As a courtesy, we will submit your claims to your insurance carrier. Your insurance carrier may require additional information from you in order to process the claim. **Failure to comply with their request for information within 30 days will result in full patient responsibility for the claim.**

DISABILITY OR INSURANCE FORMS: There will be a charge for the completion of medical forms. Pre-payment is required prior to the form being completed. Please allow 5-7 business days for the completion of these forms.

MINORS: If the patient is a minor, he/she must be accompanied by Parent/Legal Guardian for each office visit. If the patient is to be seen without the parent/legal guardian, minor consent must be given in writing and signed by Parent/Legal Guardian prior to the patient being seen.

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 NHFM.

CLINICAL RESEARCH: NHFM participates in clinical research studies, and NHFM physicians are compensated (receive money) by the study sponsors to perform research trials. Patient authorizes NHFM to access his/her medical information for the purpose of evaluating eligibility of patient for current or future clinical research studies. Patient agrees to be contacted by NHFM regarding the possibility of being enrolled in a research study. Patient is under no obligation to enroll in any study. Study participation is voluntary and refusal to participate in a research study will not affect your continuing care with any provider at NHFM. Participation in a research study will not interrupt your regular care with any provider at NHFM.

NHFM 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 feel free to contact one of our offices :

**North Richland Hills Office
4351 Booth Calloway Rd Suite 101
North Richland Hills, TX 76180
(817) 284-1165**

**Keller Office
300 North Rufe Snow Drive
Keller, TX 76248
(817) 431-3800**

NORTH HILLS FAMILY MEDICINE

North Richland Hills Office:
4351 Booth Calloway Road, Suite 101
North Richland Hills, TX 76180
(817) 284-1165

Keller Office:
816 Keller Parkway, Suite 102
Keller, TX 76248
(817) 431-3800

Thank you for reviewing our office financial policies and notice of privacy practices. Please sign in the space provided below to acknowledge receipt of this information.

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to which I am entitled, including Medicare, private insurance and any other health plans to North Hills Family Medicine. This assignment is for services rendered to me by North Hills Family Medicine. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure this payment.

FINANCIAL POLICY

I have read and understand the financial policies of North Hills Family Medicine and agree to abide by its guidelines.

HIPAA

I have received the brochure entitled "Notice of Privacy Policies and Practices" of North Hills Family Medicine.

DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that any and all medical care that I receive at the offices of North Hills Family Medicine will be treated with the utmost confidentiality. To facilitate my medical care I hereby authorize North Hills Family Medicine to disclose PHI about my treatment and medical condition to the following individuals:

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

If you have an answering machine, may we leave messages regarding appointments, treatment, and/or other information pertinent to your healthcare and/or payment for your healthcare provided at North Hills Family Medicine?

Check One _____ Yes _____ No _____ N/A

May we send electronic messages (such as email or cellular text messages) regarding appointments, treatment, and/or other information pertinent to your healthcare and/or payment for your healthcare provided at North Hills Family Medicine?

Cellular/Mobile Phone Number _____ Yes _____ No

Email Address _____ Yes _____ No
(please print)

Patient's printed name

Date of Birth

Signature of patient or responsible party

Date

**Physical Questionnaire
North Hills Family Medicine**

(rev. 5/05)

Today's Date _____
 Name _____ Date of Birth _____ Sex _____
 Address _____ Telephone _____ Marital Status _____
 Occupation & Place of Employment _____
 What health concern are you being seen for today? _____

PAST HISTORY List your long-term medical problems and medications you are currently taking:
Medical Problems *Medications (inc. OTC, supplements & herbals)*

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Surgeries (with date and Doctor) _____

Other hospitalization (including pregnancy) _____

Allergy/Drug Reaction _____ NKDA (no allergies) _____ yes (please list) _____

Personal Health Habits

Tattoos _____	Body Piercing _____
Caffeine use _____	Exercise _____
Tobacco use _____	Calcium use _____
Alcohol use _____	Seat Belt use _____
Illicit Drug use _____	Last tetanus booster _____
Living Will/Advanced Directive _____	Organ Donation _____

Family History

Health Maintenance

	Age	Health Problems	If not living age at death	Cause of death	Test	Dates			
Father					PAP				
					Mammogram				
					Self Breast Exam				
Mother					Colon-Scope / BE				
					Stool Cards				
Brothers					PSA				
					Chest X-ray				
Sisters					Blood Work				
					EKG				
Sons					Cholesterol Check				
					Annual Exam				
Daughters					Bone Density				
					Eye Exam				
					Tetanus				
Spouse					Pneumovax				
					Other				

Does anyone in your family have tuberculosis, diabetes, high blood pressure, stroke, anxiety, depression, heart disease or cancer? (please specify) _____
 Physician use only: (comments/notes)

Physician/Provider Signature: _____ **Date** ____/____/____

Review of Systems

Patient Name: _____

Date ____/____/____

Do you now or have you had any problems related to the following systems in the past month? Circle **Yes** or **No**.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Fatigue / tired	Y	N
Insomnia	Y	N
Weight Loss	Y	N
Other _____		

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N

Other _____

Allergic/Immunologic

Hay Fever	Y	N
Runny nose	Y	N
Itchy eyes	Y	N

Other _____

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N
Weakness	Y	N

Other _____

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Weight change	Y	N

Other _____

Gastrointestinal

Abdominal pain	Y	N	Difficulty swallowing	Y	N
Nausea/vomiting	Y	N	Hemorrhoids	Y	N
Indigestion/heartburn	Y	N	Rectal bleeding	Y	N
Diarrhea / constipation	Y	N	Blood in stools	Y	N

Other _____

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
Palpitations	Y	N
Edema	Y	N

Last Eye & Dental Exam

Date - Last Eye Exam: _____
Date - Last Dental Exam: _____

Integumentary

Skin rash	Y	N
Boils	Y	N
Itching	Y	N
Moles	Y	N
Hair Loss	Y	N
Bruising	Y	N
Other _____		

Musculoskeletal

Joint pain or stiffness	Y	N
Neck pain	Y	N
Back pain	Y	N
Joint Swelling	Y	N

Other _____

Ear/Nose/Throat/Mouth

Ear pain / hearing loss	Y	N
Sore throat	Y	N
Nasal congestion	Y	N
Sinus pressure / pain	Y	N
Nose bleeds	Y	N

Other _____

Genitourinary

Painful urination	Y	N
Urgency	Y	N
Frequency	Y	N
Blood in urine	Y	N
Urination at night > 1	Y	N
Vaginal discharge, pain, sores	Y	N

Other _____

Respiratory

Wheezing	Y	N
Cough – productive/dry	Y	N
Shortness of breath	Y	N
Snoring	Y	N
Blood in mucus	Y	N

Other _____

Lymphatic

Enlarged lymph nodes	Y	N
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Other _____

Psychologic

Satisfied with your life?	Y	N
Depressed?	Y	N
Suicidal?	Y	N
Abuse?	Y	N

Sexual History / Menstrual History

Change in sex drive?	Y	N	N/A
Sexual performance satisfactory?	Y	N	N/A
Painful menses (periods)?	Y	N	N/A
Irregular Menses (periods)?	Y	N	N/A

Other (i.e. sexual trauma) _____

Physician use only: (Comments/Notes)

Physician/Provider Signature: _____

Date: _____