**Woodlands Family & Community Medicine**
17521 St. Luke's Way, Suite 190
The Woodlands, Texas. 77384
Phone: (936) 447-9483 Fax: (936) 231-8200

## PATIENT INFORMATION

NAME: ______________________ SEX: [M] [F]

ADDRESS: ______________________ DATE OF BIRTH: ____________

CITY: ____________ STATE: ________ ZIP: ________ SS#: ________

HOME PHONE: ____________ CELL PHONE: ____________

WORK PHONE: ____________ MARITAL STATUS: [ ] MARRIED [ ] SINGLE

EMAIL ADDRESS: ______________________

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**EMERGENCY CONTACT** NAME: ____________ PHONE: ____________
(PLEASE LIST RELATION) NAME: ____________ PHONE: ____________

**PREFERRED PHARMACY:** NAME: ____________ PHONE: ____________

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**RESPONSIBLE PARTY** (COMPLETE IF RESPONSIBLE PARTY IS OTHER THAN THE INSURED OR PATIENT)

NAME: ______________________ DATE OF BIRTH: ____________

ADDRESS: ______________________

CITY/STATE/ZIP: ______________________ SS#: ____________

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## PRIMARY INSURANCE

NAME OF INSURED: ____________ RELATION TO PATIENT: ____________

INSURANCE COMPANY: ____________ ID: ____________

INSURANCE PHONE: ____________ GROUP: ____________

INSURED DATE OF BIRTH: ____________ SS#: ____________

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**SECONDARY INSURANCE** (IF APPLICABLE)

NAME OF INSURED: ____________ RELATION TO PATIENT: ____________

INSURANCE COMPANY: ____________ ID: ____________

INSURANCE PHONE: ____________ GROUP: ____________

INSURED DATE OF BIRTH: ____________

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**I UNDERSTAND THAT THIS FORM MUST BE COMPLETED IN ITS ENTIRETY. I UNDERSTAND THAT IF ALL OF THE ABOVE INFORMATION IS NOT COMPLETED, A CLAIM MAY NOT BE ABLE TO BE FILED TO MY INSURANCE COMPANY; THEREFORE, MAKING ME FULLY RESPONSIBLE FOR ANY CHARGES INCURRED.**

PATIENT/RESPONSIBLE PARTY SIGNATURE: ______________________ DATE: ________

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# Conditions of Services

PATIENT________________________________ DOB________________ ACCT#__________

**Assignment of Benefits and Release of Patient Healthcare Information**
I hereby authorize Woodlands Family and Community Medicine ("WFCM") to release patient healthcare information, compiled from the medical records pertaining to my services, in accordance with the policy of the clinic and Texas law, to facilitate reimbursement by a health benefit plan or third-party payor, including but not limited to, my health insurance carrier, Medicare, and any other payor or agency.
I also hereby authorize payment of insurance benefits under the terms of my policy directly to WFCM for services rendered. I am financially responsible and will pay for charges not covered by my insurance plan.

**Financial Agreement and Statement of Responsibility**
For and in consideration of services rendered or to be rendered by WFCM, I agree to pay said clinic for all services and charges. I understand that I am responsible for any health insurance deductibles, coinsurance and non-covered charges. Payment in full is due at time services are rendered. Failure to pay any outstanding debt may be considered cause for dismissal from Woodlands Family & Community Medicine.

X___________________________________ ______________________
Patient / Guarantor Signature Date

**Consent to Medical Treatment by Physician**
I, or authorized representative/legal guardian acting on behalf of the patient, do here by consent to receiving general medical services, which may include routine diagnostic procedures and such medical treatment as the physician, his/her assistants or his/her designees consider to be necessary in his/her judgment. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of treatment or examination at WFCM.

X___________________________________ ______________________
Patient / Guarantor Signature Date

**Consent to Medical Treatment by a Physician Assistant/Nurse Practitioner**
I, or authorized representative/legal guardian acting on behalf of the patient, do hereby consent to receiving general medical services from a physician assistant/nurse practitioner. I fully understand that a physician assistant/nurse practitioner IS NOT A PHYSICIAN. I further acknowledge that the general medical services provided to me by a physician assistant/nurse practitioner are the responsibility of the physician providing the services at WFCM both professionally and legally, for acts of such allied health personnel rendered during the care and treatment of his/her patients.

X___________________________________ ______________________
Patient / Guarantor Signature Date

**Release of Patient Healthcare Information**
I hereby authorize WFCM to release patient healthcare information, in accordance with the policy of the clinic, as is necessary to healthcare providers, to facilitate reimbursement by a health benefit plan or personnel of another healthcare entity for the sole purpose of providing current continuum of care including, but not limited to fax, mail or electronic submission.

X___________________________________ ______________________
Patient / Guarantor Signature Date

Do you have an advanced directive (living will)? _____YES ______NO
If yes, bring a copy to our office for our files.
If no, and you would like information on an advanced directive, please speak with your physician.

The above authorizations are valid unless you specify otherwise or revoke them in writing.

## Patient History Form

**Patient name**:______________________________ **Date**:______________________________________

**Medications**

Please list all medications that you're currently taking, prescription and nonprescription, and their dosage:

| Medication | Dose |
|---|---|
| ____________________________ | ____________ |
| ____________________________ | ____________ |
| ____________________________ | ____________ |
| ____________________________ | ____________ |
| ____________________________ | ____________ |
| ____________________________ | ____________ |
| ____________________________ | ____________ |
| ____________________________ | ____________ |
| ____________________________ | ____________ |
| ____________________________ | ____________ |
| ____________________________ | ____________ |

**Allergies**

Are you allergic to any medications?

☐ YES ☐ NO

If yes, please list the name of the medication the type of reaction:

____________________________________________

____________________________________________

____________________________________________

Are you allergic to any foods?

☐ YES ☐ NO

If yes, please list:_____________________________

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**Past Medical History**

**Please indicate if you have ever experienced any of the following conditions:**

- ☐ Alcohol dependence
- ☐ Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood clots
- ☐ Broken bones
- ☐ Cancer
  Type:_____________________
- ☐ Chronic blood thinner use
- ☐ Chronic bronchitis
- ☐ Chronic sinusitis
- ☐ Congestive heart failure
- ☐ COPD/emphysema
- ☐ Depression
- ☐ Diabetes type I
- ☐ Diabetes type II
- ☐ Esophageal reflux
- ☐ Gallbladder stones
- ☐ Gout
- ☐ Headache
- ☐ Heart attack
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irregular heartbeat
- ☐ Insomnia
- ☐ Irritable bowel syndrome
- ☐ Hepatitis
- ☐ Kidney stones
- ☐ Liver disease
- ☐ Low blood pressure
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Palpitations
- ☐ Seizure/epilepsy
- ☐ Sleep apnea
- ☐ Stomach ulcer
- ☐ Stroke or TIA
- ☐ Thyroid disease
- ☐ Tinnitus
- ☐ Tuberculosis
- ☐ Other:_____________________

**Surgical History**

**Please check all that apply and the date of the procedure:**

| Procedure | Date | Procedure | Date |
|---|---|---|---|
| ☐ Angioplasty | ___ /___ /___ | ☐ Gastric bypass | ___ /___ /___ |
| ☐ Angioplasty with stent | ___ /___ /___ | ☐ Hernia repair | ___ /___ /___ |
| ☐ Appendectomy | ___ /___ /___ | ☐ Hip replacement | ___ /___ /___ |
| ☐ Back surgery | ___ /___ /___ | ☐ Knee replacement | ___ /___ /___ |
| ☐ Carpal tunnel release | ___ /___ /___ | ☐ Liver biopsy | ___ /___ /___ |
| ☐ Cataract extraction | ___ /___ /___ | ☐ Pacemaker | ___ /___ /___ |
| ☐ Colon surgery | ___ /___ /___ | ☐ Thyroidectomy | ___ /___ /___ |
| ☐ Coronary artery bypass graft | ___ /___ /___ | ☐ Tonsillectomy | ___ /___ /___ |
| ☐ Gallbladder | ___ /___ /___ | ☐ Other: _____________ | ___ /___ /___ |

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**Female Surgical History**

**Please check all that apply:**

| Procedure | Date |
|---|---|
| ☐ Breast implants | ___ /___ /___ |
| ☐ Bilateral tubal ligation | ___ /___ /___ |
| ☐ Breast biopsy | ___ /___ /___ |
| ☐ Cesarean section | ___ /___ /___ |
| ☐ D&C | ___ /___ /___ |
| ☐ Breast reduction | ___ /___ /___ |
| ☐ TAH/BSO (total abdominal hysterectomy) | ___ /___ /___ |
| ☐ Vaginal hysterectomy | ___ /___ /___ |
| ☐ Other:___________________ | ___ /___ /___ |

**Male Surgical History**

**Please check all that apply:**

| Procedure | Date |
|---|---|
| ☐ Prostate biopsy | ___ /___ /___ |
| ☐ TURP (transurethral resection of the prostate) | ___ /___ /___ |
| ☐ Vasectomy | ___ /___ /___ |
| ☐ Other: _________________ | ___ /___ /___ |

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**Family History**

**Please check if any family member has had any of the following conditions and indicate the name of the affected member, the age of onset and/or if it was the cause of death.**

☐ Adopted

| | Mother | Father | Sibling(s) | Children | Grandparents | Cause of death |
|---|---|---|---|---|---|---|
| ☐ Alcoholism | | | | | | |
| ☐ Alzheimer's | | | | | | |
| ☐ Heart disease | | | | | | |
| ☐ Cancer Type:_______ | | | | | | |
| ☐ Depression | | | | | | |
| ☐ Diabetes | | | | | | |
| ☐ High blood pressure | | | | | | |
| ☐ High cholesterol | | | | | | |
| ☐ Kidney disease | | | | | | |
| ☐ Osteoporosis | | | | | | |
| ☐ Stroke | | | | | | |
| ☐ Seizures | | | | | | |

## Social History

Type of employment_________________________ Previous work, if retired___________________________

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Do you currently use tobacco? ☐ Yes ☐ No If yes, how many packs per day? ____________
Have you previously smoked? ☐ Yes ☐ No If yes, how many packs per day? ____________
Other tobacco units per day (dip, cigars, etc.)?
Units per day? __________ Years used? __________ Year quit? __________

Do you drink caffeine? ☐ Yes ☐ No Type? ___________ Amount Daily? _____________
Do you drink alcohol? ☐ Yes ☐ No ☐ Daily ☐ Weekly ☐ Monthly Amount:__________

Religious preference (optional)__________________________________

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## Immunizations

Are your immunizations current? ☐ Yes ☐ No
Do you have copies of your immunization records? ☐ Yes ☐ No

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## Pharmacy Information

Do you have a preferred pharmacy? ☐ Yes ☐ No

Pharmacy:_________________________________ Phone Number:___________________

Address:_____________________________________________________________________

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## Health Maintenance

Last mammogram: ______________________ Results: _______________
Last Well Woman Exam: __________________ Results: _______________
Colonoscopy: ___________________________ Results: _______________
Last lab drawn: __________________________ Results: _______________
Flu shot: _______________________________
Pneumonia shot:_________________________
Tetanus shot:____________________________

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**Additional Information:** ______________________________________________________________

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Are you interested in any cosmetic products or procedures to decrease aging of the skin (wrinkles, fine lines, age spots, melasma, acne etc.)? ☐ Yes ☐ No

## HIPPAA Authorization for Release of Information Form

I hereby authorize use or disclosure of protected health information about me as described below.

**RECORDS ON (PATIENT NAME)**______________________________ **(DOB)**______________

The following specific person or class of persons or facility is authorized to make the requested use or disclosure:

**RECORDS MAILED FROM:** ______________________________

______________________________

______________________________

The following person or class of persons may receive disclosure of protected health information about me:

**RECORDS MAILED TO:**

**Brent Allmon, M.D.**
**17521 St. Luke's Way, Suite 190**
**The Woodlands, TX 77384**
**Phone: 281.719.8450**
**Fax: 936.321.4469**

Specific *description* of information to be released (must include date(s) of service):

Labs, EKG, All tests, All Dr. Notes, Shot records.

The information to be released will be used for the *purpose* described below:

Continuing Care

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations. I may revoke or withdraw this authorization by notifying ______________ in writing of my desire to revoke it. However, I understand that any action already taken in advance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

This authorization will expire on ______________________, or 1 (one) year after the date of said authorization.

***THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.***

| Signature of Individual | Date of Signature | Date of Birth or SS Number |
|---|---|---|

--OR, if applicable--

| Signature of Guardian | Date of Signature | Description of Guardian's Personal Representative's Authority to Act for the Individual |
|---|---|---|

A copy of this completed, signed and dated form must be given to the individual or person signing on the individual's behalf.

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# PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO DESIGNATED REPRESENTATIVE(S)

I, ______________________________________________, give my authorization to release my protected health information including, but not limited to, results of my laboratory tests, x-ray and other test results to the following designated representative(s):

Patient Initials

___________ My Spouse (Name) ____________________________________

___________ My Child (Name) ____________________________________

___________ Other (Name) ____________________________________

___________ Personal Representative ____________________________________

___________ May be left on my voice mail at home.

___________ May be left on my voice mail at work.

___________ May be left on my cell phone.

___________ MAY NOT BE GIVEN TO ANYONE OTHER THAN MYSELF.

______________________________________________________________________________

Patient signature Date

______________________________________________________________________________

Witness Date

As a patient, you have the right to revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, the clinic must receive the revocation in writing. The revocation must include: 1) the patient's name, address, and date of birth, 2) the patient's desire to revoke the authorization, and 3) the date of the revocation and the patient's signature. All revocations must be sent in writing to the attention of Dr. Allmon or Dr. Kerschenbaum at 17521 St. Luke's Way, Suite 190, The Woodlands, Texas, 77384 and will not be considered effective until received by the clinic.

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# Acknowledgment of Review of Privacy Practices

I, the undersigned, have reviewed the WFCM privacy practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of the privacy practices.

______________________________________________ __________________________________
Signature of Patient or Representative Date

__________________________________________________________________________________
Printed Name of Patient or Representative

_______________________________________________________
Capacity of Representative
(Parent, Guardian, Trustee, Executor, Power of Attorney)

_______________________________________________________
Street Address

_______________________________________________________
City, State, Zip Code

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# POLICY REGARDING MISSED APPOINTMENTS

## Effective Jan. 1, 2014

**(posted July 16, 2013)**

We are dedicated to helping our patients and appreciate those who value this dedication of time, energy and service. We receive many calls from patients who wish to be seen on the same day. Our schedule is often full. Last minute cancellations and no-shows adversely affect other patients.

**Therefore, effective Jan. 1, 2014:**

- **All no-show/missed appointments will result in a fee of $50.**
- **The same $50 fee will also apply to patients who do not give us at least a 24-hour cancellation notice.**

Your understanding and cooperation is appreciated.

Dr. Brent Allmon, M.D.
Dr. Joel Kerschenbaum, M.D.

**Patient signature**____________________________ **Date**____________________________

# Prescription Refill Policy

Effective 9/10/12, revised 3/15/13

Currently, our office receives a large-volume of calls and faxes daily for medication refill requests. Our office can no longer safely manage this volume of phone and fax requests. As of September 10, 2012, we have a new prescription refill policy. We understand that this is a change for both you and us. We hope to work together to ensure safe, efficient and high-quality medical care. Thank you for being our valued patient!

It is typically my practice to give prescriptions with refills for 6 months at a time to coincide with six-month followup appointments for monitoring. It is very important to request your prescriptions during your routine office visits. In order to ensure that you do not run out of your medications, please make sure to schedule a followup appointment at the end of each visit. If office visits are scheduled and kept on a regular basis, prescriptions are refilled at these visits, and pharmacies follow instructions on prescriptions given, then requests for refills outside of office visits should rarely occur.

As of September 10, 2012, requests made for prescription refills made outside of an office visit may be subject to a fee:

1. $15.00 may be charged for 1-3 prescription refills that or not requested during an office visit
2. $25.00 may be charged for 4+ prescription refills that are not requested during an office visit.

To request a refill, please leave a detailed message on our refill request voicemail. **Please allow 2 business days for refill requests to be completed.**

Ways to reduce unnecessary refill requests and medication errors:

1. We do require office visits on a regular basis for all of our patients taking prescription medication. The interval for followup will vary depending on the type of medication you are prescribed. Please be sure you have enough medication to last until your next scheduled visit.
2. Before you come to your regular appointment, you should look over your medications, diabetic supplies, inhalers etc. to determine if you need to request any new prescriptions at your appointment.
3. Please bring all of your prescription bottles with you to your appointment. This is important to make sure that you're taking the correct medications in the correct dosages. We will to take the time to carefully review your medications and write for refills at your office visit.
4. It is your responsibility to schedule a followup appointment before you run out of your medication. We recommend you schedule your next visit before you leave our office.
5. If you are changing pharmacies, you can usually have your new pharmacy request prescriptions be transferred from your old pharmacy.

**“Auto-Renewal”, “Auto-Fax”, “Readyfill” etc.**

Most of the requests for refills that we receive are generated automatically from the pharmacy without the patient's knowledge. "Auto-renewal" or "Auto-Fax" programs with most pharmacies are at fault for most of these requests. ***As of March 15, 2013, we will no longer respond to refill requests that are faxed from the pharmacy. If you are in need of a refill we expect you to contact us directly and leave a detailed message on our Refill Request Voicemail.***

Reasoning:

From my research, the main benefit for "auto renewal" is for the pharmacy. This generates a constant stream of cash flow for pharmacies and often does not benefit the patient. It is my experience that when we receive "Auto-renewal" refill requests from the pharmacy, the patient usually still has medication and is not actually in need of refill. In many cases, the pharmacy is requesting a refill on behalf of the patient without their knowledge and may be billing insurance for the medication regardless of whether the prescription was picked up by the patient. Refilling prescriptions without a patient's approval raises the possibility of insurance fraud, state officials say. According to the *L.A. Times*, one national pharmacy chain is under federal investigation for this very reason.

“Auto Renewal” also increases chance for medication errors. Consider this common example:

> “In the past few weeks we heard from a patient utilizing the automatic refill system who picked up three prescriptions but later called the pharmacy to report he had picked up a blood pressure pill called Norvasc, which his doctor had previously discontinued. Fortunately, he hadn’t yet taken any. In another case a patient’s Cardizem, a heart medication, was increased from 240 mg to 360 mg. The elderly gentleman purchased the new prescription for diltiazem 360 mg but also received the diltiazem 240 mg prescription that had been filled earlier through the automatic refill program. After receiving a call from the confused patient, the pharmacist contacted the patient’s doctor to determine which strength the patient should be receiving. Had the patient accidentally taken both strengths of Cardizem, it could have caused serious heart or blood pressure complications.”

Acknowledgement of Receipt:

Patient Signature _______________________________ Date ________________________

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# *FINANCIAL POLICY*

*We require all patients to pay at time of service. You will be charged at every visit for any outstanding deductible, co-insurance or co-pay due, as well as any fees for services not covered by your insurance plan.*

| Your Plan | What You Do | What We Do |
|---|---|---|
| **Medicare** | Pay your deductible ($147 for 2014) and co-insurance (20% of the allowable.) If you request any services that Medicare does not cover, you agree in writing to pay our regular fee for those services. | We will file Medicare for you. |
| **Medicare + Secondary Insurance** | No payment due at time of service. | We will file Medicare and your secondary insurance for you. |
| **Commercial Insurance** | Pay your deductible, co-insurance or co-pay at time of service. | We will file your insurance for you. |
| **Insurance we are not contracted with** | Pay the visit in full at time of service. | We will provide a receipt for your services for you to file with your insurance for reimbursement. |
| **Health Savings Account (HSA)** | Your HSA credit card may be used | We will file your insurance and if the amount due is not paid, you may use your HSA. |

## *Additional Charges:*

- No Show/Cancellation < 24hrs: $50
- Completion of Forms: $25 to $50, based on time
- Out of office prescription refills: $15 to $25
- Prior Authorization for medication (if required by your insurance): $25