HERRERA MEDICAL GROUP

REGISTRATION FORM

Today's Date: [Date]	PCP:

PATIENT INFORMATION

Patient's last name: First:	Middle: [Choose an item]	Marital status: [Choose an item]

Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ○ M ○ F

Address:

Social Security no.:	Home phone no.:	Cell phone no.:
Email:	Employer:	Employer phone no.:

Chose clinic because/referred to clinic by (Please choose one option): ○ [Doctor's name] ○ [Choose an item]

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here?	○ Yes ○ No	Is this patient covered by insurance?	○ Yes ○ No
Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance: [Choose an item] | Other: [Other insurance]

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: [Choose an item] | Other:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: [Choose an item] | Other:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ Date _____

HERRERA MEDICAL GROUP

CONSENT TO TREAT

1. I _____ (patient name) give permission for HERRERA MEDICAL GROUP to give me medical treatment.

2. I allow HERRERA MEDICAL GROUP to file for insurance benefits to pay for the care I receive.

   I understand that:

   - HERRERA MEDICAL GROUP will have to send my medical records information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of the services if my insurance does not pay or I do not have insurance.

3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my provider.

PATIENT SIGNATURE:_____

PARENT OR GUARDIAN SIGNATURE:_____

PRINT NAME:_____DATE:_____

MEDICAL HISTORY
REVIEW OF SYSTEM FORM

DATE:_____ NAME:_____ DATE OF BIRTH_____
____MARRIED ____SINGLE ____DIVORCED ____WIDOWED; OCCUPATION:_____
NO.OF CHILDREN:____TOBACCO USE: YES/NO HOW MUCH?_____/DAY HOW LONG? DATE QUIT____
ALCOHOL USE: HOW MUCH PER DAY?_____CAFFEINE (COFFEE,TEA,COLAS) PER DAY_____

PAST ILLNESSES OF YOURSELF AND FAMILY:

YOU/YOUR FAMILY	YOU/YOUR FAMILY	YOU/YOUR FAMILY
☐ ☐ ALCOHOLISM	☐ ☐ HIGH BLOOD PRESSURE	☐ ☐ STROKE
☐ ☐ ANEMIA	☐ ☐ KIDNEY DISEASE	☐ ☐ SUICIDE ATTEMPT
☐ ☐ ASTHMA	☐ ☐ LIVER DISEASE	☐ ☐ THYROID DISEASE
☐ ☐ CANCER/TUMOR	☐ ☐ HEPATITIS	☐ ☐ TUBERCULOSIS, TB
☐ ☐ DIABETES	☐ ☐ LUNG DISEASE	☐ ☐ ULCER IN GI TRACT
☐ ☐ DRUG ABUSE	☐ ☐ MENTAL ILLNESS	☐ ☐ VENEREAL DISEASE
☐ ☐ DEPRESSION	☐ ☐ OSTEOARTHRITIS	☐ ☐ HIGH CHOLESTEROL
☐ ☐ EPILEPSY/SEIZURES	☐ ☐ OSTEOPOROSIS	☐ ☐ HIV/IMMUNE DX
☐ ☐ GLAUCOMA	☐ ☐ PHLEBITIS	☐ ☐ OTHER_____
☐ ☐ HEART DISEASE	☐ ☐ RHEUMATIC ARTHRITIS	

PAST SURGICAL HISTORY: (PLEASE INCLUDE DATES)

_____
_____
_____
_____

REVIEW OF SYSTEMS-PLEASE CHECK EACH ITEM "YES" OR "NO" AS THEY RELATE TO YOUR HEALTH:

CONSTITUTIONAL:	Yes	No
Weight Loss	☐	☐
Fatigue	☐	☐
Fever	☐	☐
EYES:		
Glasses/Contacts	☐	☐
Eye Pain	☐	☐
Double Vision	☐	☐
Cataracts	☐	☐
EAR,NOSE,THROAT:		
Difficulty Hearing	☐	☐
Ringing in Ears	☐	☐
Vertigo	☐	☐
Sinus Trouble	☐	☐
Nasal Stuffiness	☐	☐
Frequent Sore Throat	☐	☐
CARDIOVASCULAR:		
Murmur	☐	☐
Chest Pain	☐	☐
Palpitations	☐	☐
Dizziness	☐	☐
Fainting Spells	☐	☐
Shortness of Breath	☐	☐
Difficulty lying Flat	☐	☐
Swelling Ankles	☐	☐
ENDOCRINE:		
Loss of Hair	☐	☐
Heat/Cold Intolerance	☐	☐

RESPIRATORY	Yes	No
Cough	☐	☐
Coughing Blood	☐	☐
Wheezing	☐	☐
Chills	☐	☐
GASTROINTESTINAL:		
Heartburn/Reflux	☐	☐
Nausea/Vomiting	☐	☐
Constipation	☐	☐
Change in BMs	☐	☐
Diarrhea	☐	☐
Jaundice	☐	☐
Abdominal Pain	☐	☐
Black or Bloody BM	☐	☐
GENITOURINARY:		
Burning/Frequency	☐	☐
Nighttime	☐	☐
Blood in Urine	☐	☐
Erectile Dysfunction	☐	☐
Abnormal Discharge	☐	☐
Bladder Leakage	☐	☐
ALLERGIC/IMMUNOLOGIC:		
Hives/Eczema	☐	☐
Hay Fever	☐	☐
PSYCHIATRIC:		
Anxiety/Depression	☐	☐
Mood Swings	☐	☐
Difficult Sleeping	☐	☐

HEMATOLOGY/LYMPH	Yes	No
Easy Bruising	☐	☐
Gums Bleed Easily	☐	☐
Enlarged Glands	☐	☐
MUSCULOSKELETAL:		
Joint Pain/Swelling	☐	☐
Stiffness	☐	☐
Muscle Pain	☐	☐
Back Pain	☐	☐
SKIN:		
Rash/Sores	☐	☐
Lesions	☐	☐
Itching/Burning	☐	☐
NEUROLOGICAL:		
Loss of Strength	☐	☐
Numbness	☐	☐
Headaches	☐	☐
Tremors	☐	☐
Memory Loss	☐	☐

FEMALES ONLY:
Date Last Mammogram_____
Normal_____Abnormal_____
Date last PAP_____
Normal_____Abnormal_____
Age Onset Periods_____
Age Onset Menopause_____
Periods Regular? Yes_____No____
Number Pregnancies_____

SIGNATURE/REVIEWING PHYSICIAN_____

NEW PATIENT- PLEASE COMPLETE THE FOLLOWING

Name:_____ Date:_____

CURRENT MEDICATIONS: INCLUDE BIRTH CONTROL PILLS,VITAMINS, AND SUPPLIMENTS

MEDICINE NAME	HOW TAKEN?	WHO PRESCRIBES?	NEED RX
			YES/NO
			YES/NO
			YES/NO
			YES/NO
			YES/NO
			YES/NO
			YES/NO

PREFERRED PHARMACY:_____ LOCATION:_____

PREVIOUS HEALTH CARE PROVIDERS IN PAST FIVE YEARS:

NAME	CITY/STATE	PROBLEM CARED FOR:	STILL SEEING?	REFERRAL?
			YES/NO	YES/NO
			YES/NO	YES/NO
			YES/NO	YES/NO
			YES/NO	YES/NO

ALLERGIC AND ADVERSE REACTIONS TO MEDICATIONS

NAME OF MEDICATION:	ADVERSE REACTION

ADDITIONAL INFORMATION:

LAST MAMMOGRAM?_____ WHERE?_____ LAST PAP?_____ GYN?_____

LAST COLONOSCOPY?_____ NORMAL?_____ DR?_____ REPEAT DATE?_____

APPROXIMATE DATE OF LAST BLOODWORK?_____ RECTAL EXAM?_____

VACCINE DATES:

TETANUS?_____ PNEUMONIA?_____ FLU?_____ HEPATITIS B SERIES?_____

OFFICE POLICY FOR PRESCRIBING CONTROLLED MEDICATION

DATE:_____

PATIENT NAME:_____

DATE OF BIRTH:_____

I_____ am aware that I will be given one written controlled prescription after a UA test. Please note: post dated controlled medication prescriptions will no longer be allowed.

I agree that I am responsible for the prescription and that if I lose it or misplace it I will not be able to have another prescription written until my next follow-up appointment. I understand the written prescription will expire and must be filled within 21 days of the allowed fill by date.

PATIENT:_____ DATE:_____

WITNESS:_____ DATE:_____

Acknowledgement of Receipt of Notice

My signature below indicates that I have been provided with a copy of the Family Medical Associates' ***Notice of Privacy Practices,*** and have had an opportunity to ask questions concerning this policy.

_____ _____

Signature of Patient or Legal Representative *Date*

_____

Representative's Relationship to Patient

Preferences for Patient Notification

My signature below indicates the method(s) in which I choose to be contacted in the event that I need to be notified of information concerning my healthcare. My consent is also given to contact the individuals listed below in case I cannot be reached. My preferences checked below will remain in effect until changed by me in writing. Please contact me: (***Check all that apply)***

By Mail: **Alternate Address or Telephone:**

☐ Home Address ☐ Other: _____

_____

_____

By Telephone:

☐ Home Telephone ☐ Other: _____

☐ Cell Telephone _____

☐ Answering machine/Voice mail
_____Home only
_____Cell only
_____Both

Permission to Inform Others

I give my consent to Family Medical Associates to inform the following individuals of important information concerning my healthcare in the event I cannot be reached: ***Provide name of individual(s).***

Name: **Relationship to Patient:**

_____ _____

_____ _____

_____ _____

_____ _____

Signature of Patient or Legal Representative *Date*

_____

Representative's Relationship to Patient

HERRERA MEDICAL GROUP

FINANCIAL POLICY AGREEMENT

As part of our ongoing commitment to treating our patients with complete courtesy, dignity and respect, we regard your complete understanding of our financial policies as an essential element of your care and treatment. If you have any questions regarding these policies, please discuss them with our billing specialists, prior to treatment. The following is a summary of our payment policy.

INSURANCE & PATIENT RESPONSIBILITY

Payment is required at the time services are rendered unless other arrangements have been made, *in advance*. This includes all applicable copays, co-insurance payments, and deductibles for the insurance companies with whom we are contracted. The practice accepts cash, in state personal checks, Visa, MasterCard, Discover and American Express. There is a $30.00 service charge for returned checks.

With regards to insurance, we bill participating insurance companies as a courtesy to our patients. Patients are expected to pay their deductible and/or coinsurance/copay at the time of service. You must present an insurance card at each visit. If you or your dependent(s) do not present a valid insurance card at the time of your visit, you will be responsible for the visit cost in full.

PATIENT RESPONSIBILITY

Please be aware that some and perhaps all, of the services you receive, may be non-covered or not considered reasonably necessary by your insurance company. In the event your insurance company determines a service to be "non-covered," you will be responsible for the service(s) performed. The physicians in the office will be unable to change their, "normal course of treatment," due to non-covered services or limitations of your insurance benefits. Payment for non-covered services will be due at the time of service or upon receipt of a statement from our office.

PAYMENT ARRANGEMENTS

Patients with an outstanding balance of 30 days or more overdue, must make payment arrangements prior to scheduling appointments. We realize that people may have financial difficulty. Payment plans must be set up by the patient in person and will automatically be deducted from the credit/debit card specified for that arrangement.

MINOR PATIENTS

Regardless of marital status, we will look to the adult accompanying the patient for payment due at the time service is rendered to the minor patient. If a parent other than the one accompanying the patient to the office is legally responsible for the account, a copy of the court decree will need to be submitted to the office. Minors and dependents must present a valid insurance card at each visit if a claim is to be filed. In addition, minors cannot receive medical treatment without the signed consent of a parent or legal guardian.

CLAIMS SUBMISSION

We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their requests.

Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim or not. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. If we have not received payment from your insurance company within 45 days of the date of service, you will be expected to pay the balance in full. You are responsible for your charges. If you have insurance coverage with a plan with which we are not contracted or you have a pre-existing clause in your policy, the charges for your care and treatment will be due prior to treatment.

NONPAYMENT

Statement balances must be paid within thirty days to avoid late payment penalty charges. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless arranged in advance with a signed payment arrangement put in place. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. Any collection agency fees, (in addition to your unpaid balance), will be your responsibility.

MISSED APPOINTMENTS & LATE CANCELATIONS

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Our office requires a 24-hour cancelation notice. In the event you miss or fail to cancel your appointment 24 hours in advance, there is an administrative fee of $25.00 which must be paid prior to scheduling a future visit. Chronic rescheduling or missing of appointments may be grounds to terminate the physician/patient relationship.

Signature of patient or authorized representative: _____

Printed name of patient or authorized representative: _____

Date: _____

HMG

HERRERA MEDICAL GROUP

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name_____

Date of Birth_____

Social Security #_____

Address_____

I Hereby Request and Authorize:

Name_____

Address_____

Phone_____ Fax_____

To Release and send the Following Information:

Date(s) of service (if known):_____

___Complete Record (including records from previous physicians or providers)

___Complete Hospital Records

___Records from _____ to _____ only.

___Records concerning the following condition(s) only:_____

Release by Mail or Fax to: DR._____

571 W. Main St. Suite 120

Lewisville ,TX 75057

972-221-3500/Fax 972-221-3522

Signature_____ Date:_____