



# Family Medicine Associates of Round Rock, P.A.

7200 Wyoming Springs Rd., Suite 600 Round Rock, TX 78681 (512)-244-1995

Board Certified in Family Practice

## PATIENT INFORMATION

Name \_\_\_\_\_

Street/Mailing Address: \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_

Sex (Circle One): M/F Social Security # \_\_\_\_\_ DOB: \_\_\_\_\_

Cell Phone : \_\_\_\_\_ Work Phone \_\_\_\_\_

Alternate Phone #: \_\_\_\_\_ Email address \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Marital Status \_\_\_\_\_

Fill out Dependent Information Below:

Spouse Name:	DOB:	
1. Dependent Name:	DOB:	Relationship:
2. Dependent Name:	DOB:	Relationship:
3. Dependent Name:	DOB:	Relationship:

Emergency Contact \_\_\_\_\_  
Name Phone Relationship

How did you hear about us? \_\_\_\_\_

## RESPONSIBLE INSURED PARTY

**Check here if same as patient** \_\_\_\_\_ (If different, please fill out below):

Name: \_\_\_\_\_

Street Address \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_

Sex: (Circle One) M/F Social Security # \_\_\_\_\_ DOB: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone \_\_\_\_\_ Alt Phone \_\_\_\_\_

Employer: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

1. CONSENT TO TREATMENT – I feel that medical examination and treatment are necessary and that such medical care will be performed by a duly licensed physician of the State of Texas and by his/her employees. I hereby grant my authorization and consent for examination and treatment. I understand that payment is expected at the time of service.
2. I hereby grant my authorization to file my insurance with the applicable health plan in which my physician is a participating provider and assign payment to the physician when payment has not been made at time of service.

\_\_\_\_\_  
Signature of Patient, Parent or Guardian

\_\_\_\_\_  
Date



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### Office Policy – Please Read Carefully

Payment is due at the time of service unless prior arrangements are made. We accept cash, personal checks, Visa, Mastercard and Discover.

In order to control our cost of billing, we request that office visits be paid at the time services are rendered. We do not accept insurance forms in lieu of payment but will provide you with a receipt that will assist you in collecting payment from your insurance carrier if we do not have a current contract with your insurance company. Please do not lose your receipt – there is a charge for additional copies.

We are providers for several PPO and HMO insurance plans. If we are providers under your plan, we will file for you. Copayments are due prior to seeing the physician at the time of service. You are responsible for obtaining necessary referrals prior to any specialist visits. You are responsible for all non-covered charges. If our insurance does not make payment within 60 days, you may be asked to call them for the status on it. Should your insurance company process your claim incorrectly, you may be billed for the balance on your account.

Frequently, insurance companies require additional information from the patient before processing a claim. If you receive such information in the mail, please fill out the form and mail it to your insurance company as quickly as possible. Failure to do so will make you responsible for the entire bill regardless of our contract status. We will expect payment of deductible and coinsurance amounts at the time of service, or proof that your deductible has been met. We require your coinsurance amount prior to any elective surgery or procedures. We allow 60 days for processing of insurance claims. At the end of that time, if your insurance has not paid, the entire balance becomes your responsibility.

**Motor Vehicle Accidents:** We do not file third party insurance for motor vehicle accidents or liability claims. If personal injury protection (PIP) insurance is available to you, through you or another party, it will become the primary insurance and your health insurance will become secondary. If your PIP is depleted, send us proof and your health insurance may pick up the balance. We will be happy to file the secondary insurance with the insurance companies we are contracted with once we have received proof of depletion. We do not wait for claims to be settled in or out of court. Payment is expected, in full, at time of services. \_\_\_\_\_ (PLEASE INITIAL)

**Worker’s Compensation:** Family Medicine Associates of Round Rock, P.A. does not see worker’s compensation injuries or illnesses. If there is a question as to the possibility that you may have a worker’s compensation injury or illness, you need to speak with your employer to make a determination. We do not make these determinations. You will need to see a worker’s compensation physician with another facility. \_\_\_\_\_ (PLEASE INITIAL)

**Medicare:** Family Medicine Associates of Round Rock, P.A. will accept assignment for our Medicare patients. If you do not have a Medicare supplement, we expect you to pay your 20 percent and, if not met, your deductible at the time of your visit.

By signing below, I hereby authorize Family Medicine Associates of Round Rock, P.A. to furnish medical information concerning my present illness or injury, including hepatitis and HIV information. To any specialist(s) and/or insurance companies for the purposes of obtaining treatment. I further authorize any specialist(s) and other care providers to furnish all medical information concerning my present illness or injury to Family Medicine Associates of Round Rock, P.A. I agree to allow faxing or emailing of this information when necessary.

By signing below, I authorize Family Medicine Associates of Round Rock, P.A. or their designee to provide my child or me with reasonable and proper medical care according to today’s standards. I also authorize Family Medicine Associates of Round Rock, P.A. to release any information, including medical information, they have acquired in the course of treatment to my insurance company or companies or any third party payor so that they may obtain payment for medical services rendered. Should Family Medicine Associates of Round Rock, P.A. accept assignment on my claim, I authorize the insurance company or any third party payor to pay any benefits directly to this office. I agree that the insurance information given is correct and if I fail to notify Family Medicine Associates of Round Rock, P.A. of changes in my insurance coverage, I may be responsible for all copays, coinsurance, deductibles and non-covered services and that payment is due at the time services are rendered.

By signing below, I agree that I am financially responsible for the account even though insurance may be pending on all or a portion of the charges. Should insurance membership verification not indicate coverage, I agree to pay in full for services rendered. I understand that I am responsible for all copays, coinsurance, deductibles and non-covered services, and that payment is due at the time that services are rendered.

By signing below, I hereby acknowledge that I have been presented with a copy of Family Medicine Associates of Round Rock, P.A.’s Notice of Privacy Practices.

I understand and agree that the signatures and dates on this form will not expire without written notice or in the case that a minor becomes an adult and that a scan or photocopy of this form is considered valid as the original.

\_\_\_\_\_  
Patient’s Signature, Parent or Legal Guardian

\_\_\_\_\_  
Date

rev 09162014



Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

To assist us in helping assess your risk for certain diseases and give us information as to how to direct your physical - please complete the following form:

In your family, do you have any of the following diseases?

- Heart disease - would be anything such as angina, bypass surgery, angioplasty or stent placement, valve disease, heart attack or rhythm issues
- Hypertension or High Blood Pressure
- Stroke
- Diabetes - adult or juvenile onset or “borderline or diet controlled”
- Cancer - any type of cancer for this question
- Mental Illness - depression, anxiety, alcoholism, schizophrenia, bipolar disease, drug use. Alzheimer’s or other forms of dementia
- Cholesterol: on or should be on treatment
- Other - things that seem to run in the family

Please record **approximate age of onset** and some brief description of problems for the family members with these problems.

	Heart Disease	High Blood Pressure	Stroke	Diabetes	Cancer (type)	Mental Illness or Dementia	High Cholesterol
Mother							
Father							
Mother’s Father							
Mother’s Mother							
Father’s Father							
Father’s Mother							
Sisters							
Brothers							

Any other significant family illnesses? \_\_\_\_\_