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 form 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 adults
and that a scan or photocopy of this form is considered valid as the original.

_____ _____

Patient's Signature, Parent or Legal Guardian Date

Family Medicine Associates of Round Rock, P.A. — Past Medical History

Name_____ Age: _____ Date: _____
Date of Last Physical Examination: _____

	PATIENT		FAMILY	
	YES	NO	YES	NO
Heart Attacks				
Serious Heart Trouble				
High Blood Pressure				
Strokes				
High Cholesterol				
Cancer				
Diabetes (high sugar)				
Thyroid Disease/Goiter				
Glaucoma				
Migraine Headaches				
Motion Sickness				
Cataracts				
Color Blindness				
Alcoholism/Alcohol Abuse				
Anemia (Low Blood Count)				
Easy Bleeding Problem				
Epilepsy (Seizures)				
Mental/Nervous Disorder				
Tuberculosis Exposure				
Pneumonia				
Emphysema				
Asthma				
Blood Clot to Lung/Leg				
Pleurisy				
Stomach Ulcer				
Gallbladder Disease				
Hepatitis/Yellow Jaundice				
Liver Disease/Cirrhosis				
Colitits/Other Bowel Disease				
Hemorrhoids/Rectal Problems				
Hernia				
Kidney Disease				
Nephritis (Kidney Infection)				
Cystitis (Bladder Infection)				
Prostate Trouble (Men)				
Gonorrhea/Syphillis/STD				
Arthritis or Rheumatism				
Any Bone or Joint Disease				
Rheumatic Fever				
Polio or Meningitis				
Hay Fever or Allergies				
Hives or Eczema				
Any Other Disease				
Osteoporosis				

Surgeries	YES	YEAR
Skin Cancer		
Appendix		
Tonsils		
Gallbladder		
Hernia		
Hemorrhoids		
Breast/Lump		
Female Organs		
Prostate		
Vasectomy		
Bilateral Tubal Ligation		
Hospitalizations		

Current Medications	YEAR

Personal History- Have you ever had?	YES
Measles 3-day (Rubella)	
Measles 10-day	
Mumps	
Chicken Pox	
Scarlet Fever/Scarlatina	
Mononucleosis ("Mono")	
Allergies to:	
Penicillin	
Sulfa	
Any Other Medicine	
Any Foods	
Any Other Allergies	
Food/Chemical/Drug Poisoning	
Blood or Plasma Transfusion	
Broken or Cracked Bones	
Sprains or Dislocations	
Lacerations Needing Sutures	
Concussion or Head Injury	
Injury to Eyes or Ears	
Use of: Hearing Aid	
Removable Denture	
Glasses/Contacts	
Recommended Surgery Which Has **NOT** Been Done?	

OB/GYN:
_____#of pregnancies _____#of live births
_____#of C-Sections _____#premature babies
_____# of miscarriages _____Abortions?
Past Menopause ("The Change")_____ When_____
Problems with any pregnancy?_____
_____
Last PAP_____
Last Mammogram_____
Weight Now_____Weight one year ago _____

SMOKING? Yes / No / Never
_____/day _____# of years
Snuff_____ Chewing Tobacco_____

BEVERAGE Amount/Week_____Liquor
_____Beer _____Wine_____Coffee

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