IMPORTANT PATIENT INFORMATION

FAMILY MEDICINE CENTER
801 McClintic Dr.
Groesbeck, TX 76642
254-729-3411

Please Keep

Welcome to Family Medicine Center, we are happy you have chosen us to take care of your health needs. We are committed to giving you the best healthcare possible. Below are our policies that are in place for the care of you, the patient, and for the staff of this clinic. If you have a question please do not hesitate to ask any staff member.

Please read all carefully and there is a page in your new patient packet that you will sign stating you have read and understand all of these policies. Please keep this information for your records.

PRIVACY NOTICE:

I understand that as part of the provision of healthcare services, Family Medicine Center creates and maintains electronic health records and other information describing among other things, my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment.

Notice of Privacy Practices provides more complete description of the uses and disclosures of certain health information. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to care out treatment, payment or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conduction or arranging for medical review, legal services and auditing functions, etc.) and the organization is not required to agree to the restrictions requested. By signing the attached form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and healthcare operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format are confidential and cannot be disclosed for reasons outside of treatment, payment health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of the signed consent is a valid.
3. I have the right to request that the use of my protected health information which is used or disclosed for the purposes of treatment, payment or healthcare operations be restricted. I also understand that the practice and I must agree to any restrictions in writing that I request on the use and disclosure of my protecte health information and agree to any restrictions in writing that I request on the use and disclosure of my protected health information and agree to terminate ar restrictions in writing on the use and disclosure of my protected health information which have been previously agreed upon.

FINANCIAL POLICY

The following are the conditions for services provided by "FAMILY MEDICINE CENTER".

PAYMENT FOR SERVICES: Our office will inform you of the amount due when you check out. This amount is due at the time services. As a courtesy to you, we will file your insurance claims if you provide us with a copy of your current insurance card. We require that you pay your co-payments, deductible, and/or charges not covered by insurance. **ALL CO-PAYMENTS ARE TO BE PAID AT TIME OF CHECK-IN** ****NOTE:** If you have a PCP listed on your insurance, that is not a provider in this clinic, you will be asked to reschedule your appointment until this is changed. It is your responsibility to make these changes before your appointment. If you are currently on the **INDIGENT OR SLIDING SCALE PROGRAMS** you are required to pay your portion at the time of visit. **NO ARRANGEMENTS** will be made for payment for a later date. These programs are a means of help for you the patient and it is your responsibility to uphold your part of the agreement for which you are to pay small fee at the time of the visit.

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COLLECTION POLICY: Delinquent accounts will be forwarded to a collection agency. We will inform you of your account status on your statement. If you are unable to pay your balance promptly, please call the business office at 254-729-3411 or 254-729-3281 to make payment arrangements. We will attempt to contact you by letter before your account is forwarded to collections.

PAYMENT FOR SERVICES PROVIDED OUTSIDE OF FMC: If you are having laboratory and/or diagnostic services. These services may be billed separately by that service provider. This includes services provided by Limestone Medical Center, Radiologist and any send out labs.

METHOD OF PAYMENTS: We accept payment with cash, personnel check, credit cards or debit cards. **RETURNED CHECKS; $**30.00 service charge will be added to all checks returned to us for insufficient funds.

LATE ARRIVALS: It is the policy of this clinic if you are more than 15 min. late you will be rescheduled.

NO-SHOW APPOINTMENTS: A fee of $25.00 may be charged for all missed appointments not cancelled at least 24 hrs. prior to the appointment time. You will be financially responsible for this fee, as insurance plans do not cover these changes. You may notify our office of any cancellations by calling 254-729-3411 during regular business hours.

PRESCRIPTION MEDICATION POLICY:

The providers of Family Medicine Center use electronic medical record system that allows electronic prescribing of medications. Medications are sent to your pharmacy through a Secure Electronic Prescription connection **"Sure Scripts"** which improves the timely and accurate transmission of your medication information.

your call within 24 business hours. If you have a MEDICAL EMERGENCY please call 911.

history through Sure Scripts. This will help your healthcare providers with information about your current and past prescriptions. This allows healthcare providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medications history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicate therapy.

"SCHEDULED" MEDICATIONS PROTOCOL:

The physicians of FAMILY MEDICINE CENTER have implemented a protocol due to the regulations of *the Texas Department of Public Safety (DPS) Regulatory Services Division (RSD)*; that we can ask for a urine drug screen at any time from those patients that have been prescribed any **SCHEDULED 2, 3, 4, or 5 medications.** Failure to allow us to do this drug screen and if abnormal results are found, can lead to not being filled and/or termination of any scheduled drugs further being given. This decision will be based individually by the attending physician.
If you have any questions regarding this please discuss them with your provider during your scheduled office visit.

REFILL MEDICATIONS: refill request on any medications will need to be called into your pharmacy and they will contact your physician electronically or by fax. On all refills please allow 48 business hours for response.

CALL BACKS: Please understand that during office hours of 8 to 5 pm nursing and physicians are with patients for that day. You can leave a message and they will return your call within 24 business hours. If you have a MEDICAL EMERGENCY please call 911.

For all concerns or issues please contact the Clinic Director, CeLinda Sackett, at 254-729-3411.
Thank you and again welcome to Family Medicine Center.

KEEP FOR YOUR RECORDS

FMC
The healing team
Family Medicine Center

Date: _____

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)		ADDRESS	
CITY, STATE	ZIP	HOME PHONE	CELL PHONE

PATIENT DATE OF BIRTH	PATIENT SSN	SEX ☐ Male ☐ Female	MARITAL STATUS ☐ Single ☐ Married ☐ Other	EMAIL

PATIENT EMPLOYER NAME	PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)	EMPLOYER PHONE

INSURED/RESPONSIBLE PARTY INFORMATION

RELATION TO PATIENT: ☐spouse ☐parent ☐guardian

NAME (FIRST -- LAST -- MIDDLE INITIAL)	ADDRESS (if different from patient)			
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER

INSURANCE INFORMATION

**PRIMARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)		PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE
**SECONDARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)		PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE

PRIMARY DOCTOR/FAMILY DOCTOR	REFFERING DOCTOR	
IN CASE OF EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to Family Medicine Center and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	DATE

RELEASE OF INFORMATION

I understand that:

- Once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- my records are protected and cannot be disclosed without written permission
- This Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE	EMAIL
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (Optional):	

REVISED: JANUARY 2016

Family Medicine Center
801 McClintic
Groesbeck, TX 76642

PATIENT: _____
(print patient name)

ACKNOWLEDGEMENT SIGNATURE SHEET:

PATIENT CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE:

I have been given a copy and read with total understanding of all **"Privacy Notice".**
I am signing this form, stating I consent to the use of disclosure of protected of protected health information about me for the purposes of treatment, payment and healthcare operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

PT/GUARDIAN SIGNATURE:_____DATE: _____

PAIN MEDICATION PROTOCOL:

I have been given a copy and read with total understanding of the**" PHYSICIANS OF FAMILY MEDICINE CENTER protocol"** due to the regulations of the TX Dept. of Public Safety, Regulatory Services Division. This is on all SCHEDULED 2, 3, 4, or 5 medications.

PT/GUARDIAN SIGNATURE:_____DATE: _____

PRESCRIPTION MEDICATION CONSENT FORM:

I have been given a copy and read with total understanding of the **"Prescription medication form".** I am agreeing that my provider at Family Medicine Center may request and use my prescription medication history from other healthcare providers and/or 3rd party pharmacy benefit payors for treatment purposes. This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation. Understanding the above, I hereby provide informed consent to Family Medicine Center to enroll me in this **SURESCRIPT PROGRAM.** I have had the chance to asked questions and all my questions have been answered to my satisfaction.

PT/GUARDIAN SIGNATURE: _____DATE:_____

FINANICAL POLICY:

I have received a copy and read with total understanding of the **"FINANCIAL POLICY".** I understand that I am responsible for any and all outstanding balances.

PT/GUARDIAN SIGNATURE: _____DATE: _____

Scanned date: _____
By: _____

FMC
The healing team
Family Medicine Center

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I _____ give Family Medicine Center my permission to release any medical information (including diagnostic information, lab results, and radiology reports) to the person/persons listed below.

I understand that if I do not list anyone below, NO information will be given to anyone other than myself. **NO EXCEPTIONS!!**

Patient signature _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

PATIENT PORTAL FAQ's

1. What is the LMC/FMC patient portal?

The Limestone Medical Center/ Family Medicine Center s a convenient and secure health-management tool you can use anywhere you have access to the Internet. Through the portal, you can:

- View your clinical record summary for each visit
- In the future, be able to correspond with your health care team. (Coming soon!)

2. How old do I have to be to participate in the Limestone Medical Center/ Family Medicine Center patient portal.

You must be at least 18 years old to participate in the LMC/FMC portal.

3. How do I sign up for the Limestone Medical Center/ Family Medicine Center patient portal?

- When your registration has been completed, you will receive an email invitation to create your account.
- Once you receive your email invitation, click the first link you see in the email and follow the directions.

4. What is included in the Clinical record Summary information?
The Limestone Medical Center/ Family Medicine Center Patient Portal includes a view of clinical data from Limestone Medical Center/ Family Medicine Center Record. Your **Health Record** includes:

- Clinical Record Summary
    - Medications
    - Allergies
    - Immunizations
- Medications

5.Who can I contact if I have trouble logging in or accessing the LMC/FMC portal?

Please contact the main number 254-729-3281 at Limestone Medical Center or 254-729-3411 for the Family Medicine Center and speak to registration, they can reset your password and if more help is needed, send you to the IT dept.

6.How can I obtain a copy of my entire medical Record.

Please call our Medical Records Department at 254-729-328

701 McClintic Dr. Groesbeck, TX 76642

Patient Portal Authorization and Disclosure Form

What is the Limestone Medical Center/ Family Medicine Center Patient Portal?

1. The **Limestone Medical Center/ Family Medicine Center** patient portal is a program that allows you online access to certain parts of your electronic medical record.
2. This service is entirely voluntary; if you wish to use this service, you must read this form and sign to authorize us to communicate with you via this mechanism.

Patient Portal Guidelines and Your Responsibilities:

1. Your login information and password protect the confidentiality of your health information. Please **DO NOT SHARE** your login or password with anyone.
2. Our patient portal is **NOT FOR EMERGENCIES.** In the event of an emergency, please call 911 or go to the nearest emergency department.

3. Email about the patient Portal will only be sent to the email you provided. Please be advised that any person with access to your email account or computer may be able to see email responses from our office that pertain to your health information.

4. **Limestone Medical Center/ Family Medicine Center Patient Portal** is not responsible for any information that you share intentionally or unintentionally with others via email or through improper network security practices on your part. Please make every effort to safeguard your password.
5. Please note that our patient portal is not a substitute for timely contact and consultation with your doctor. You should never change or discontinue any course of treatment ordered by your doctor without first consulting with him or her..
6. You must be 18 years of age or older to use the patient portal.

Privacy: **Limestone Medical Center/ Family Medicine Center Patient Portal** has in place policies and procedures regarding access to medical records by our staff and employees.

1. **Security**: For your security, please do not transmit any requests over an unsecured web browser.
2. Please note that you can discontinue use of our patient portal at any time
3. If for any reason we decide that you have violated the terms and/or abused the use of this service, or for any other reason, we can stop your use of this service at any time. You will be notified if we cancel your access to the **Limestone Medical Center/ Family Medicine Center Patient Portal** .
4. Any conflicts related to this agreement will be governed by and interpreted in accordance with the laws of the State of Texas.

5. If you believe someone has learned your password, you should immediately go to the Web site and change it. You agree not to share your username and password with unauthorized persons and to maintain that username and password in a secure place at all times. Access to the Patient Portal is a free service but we reserve the right to change this policy if needed. We strive to keep all of your protected health care information completely confidential. If you cannot reset your password, you can call us and we can reset it for you.

Exclusion of warranty and limitation of liability: Limestone Medical Center/ Family Medicine Center patient portal is provided as is, and your use of it is exclusively at your own risk. We make no warranties, express or implied about the use of this portal or the materials in it, and disclaim any express or implied warranty of accuracy or quality, and any implied warranty of merchantability, fitness for a particular purpose, or non-infringement.

I understand that:

- I have the right to revoke this authorization, in writing, at any time by sending such written notification to the person authorized to make the disclosure, identified above.
- My revocation will not be effective to the extent that the authorized person has relied on the authorization before receiving the revocation, but will be effective from that date forward.
- Failure to furnish this authorization will not affect my medical treatment/eligibility or enrollment for health coverage or the payment of health benefits.
- Once disclosed, the protected health information may no longer be protected by federal or state law and could be disclosed again by the recipient.

_____ _____

Signature of Individual or Personal representative **DATE**

A fax or photocopy of this form shall be as effective as the original.

DOB _____

If a personal representative is signing the form on behalf of the individual whose medical information is to be disclosed, please print the personal representative's name and describe his or her authority to act on behalf of theindividual.

Email Addres: _____

A fax or photocopy of this form shall be as effective as the original.

Family Medicine Center Date: _____

PATIENT MEDICAL HISTORY

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)

***** Preferred Pharmacy:**

Allergies

- ☐ NONE/No Known Allergies
- ☐ Adhesive Tape
- ☐ Anesthesia
- ☐ Aspirin
- ☐ Codeine
- ☐ Dairy Products
- ☐ Iodine/Shellfish/Contrast Dye
- ☐ Latex
- ☐ Morphine
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Wheat

OTHER:

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER	SIBLING (Brother/Sister)
Anesthesia Problems			
Arthritis			
Cancer			
Diabetes			
Heart Problems			
Hypertension			
Stroke			
Thyroid Disorder			

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Occupation: _____ ☐ Retired ☐ Disabled (reason _____)

☐**Yes** ☐**No** - Do you drink alcohol? ☐ Daily ☐ Weekly ☐ Infrequently ☐ Recovering Alcoholic

☐**Yes** ☐**No** - Do you use tobacco? ☐ Smoke (___ packs per day) ☐ Chew

Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

Medical History: Have you ever had any of the following?

- ☐ NONE of the problems listed
- ☐ allergies
- ☐ anemia
- ☐ arthritis conditions
- ☐ asthma
- ☐ arterial fibrillation
- ☐ bleeding problems
- ☐ BPH
- ☐ CAD coronary artery disease
- ☐ cancer
- ☐ cardiac arrest
- ☐ celiac disease
- ☐ chest pain
- ☐ CHF congestive heart failure
- ☐ chronic fatigue syndrome
- ☐ depression
- ☐ diabetes
- ☐ drug/alcohol abuse
- ☐ erectile dysfunction
- ☐ fibromyalgia
- ☐ GERD
- ☐ heart disease
- ☐ high cholesterol
- ☐ hyperinsulinemia
- ☐ hyperlipidemia
- ☐ hypertension
- ☐ hypogonadism male
- ☐ hypothyroidism
- ☐ infection problems
- ☐ insomnia
- ☐ irritable bowel syndrome
- ☐ kidney problems
- ☐ menopause
- ☐ migraines/headaches
- ☐ neuropathy
- ☐ onychomycosis
- ☐ organ injury
- ☐ osteoporosis
- ☐ pulmonary embolism/blood clot in legs
- ☐ seizure disorders
- ☐ shortness of breath
- ☐ sinus conditions
- ☐ stroke
- ☐ syndrome X
- ☐ tremors
- ☐ wheat allergy

Medications: List any medications you are currently taking (please include over the counter medications):

PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

MEDICATION	DOSAGE	PERSCRIBING DOCTOR

THE BERLIN QUESTIONNAIRE

Patient_____ Date_____ Physician_____

Please circle correct response:

Question	Response
Has your weight changed?	Increased Decreased No change
Do you snore?	Yes No Do not know
Snoring loudness	Loud as breathing Loud as talking Louder than talking Very loud
Snoring frequency	Almost every day 3 to 4 times per week 1 to 2 times per week 1 to 2 times per month Never or almost never
Does your snoring bother other people?	Yes No
How often have your breathing pauses been noticed?	Almost every day 3 to 4 times per week 1 to 2 times per week 1 to 2 times per month Never or almost never
Are you tired after sleeping?	Almost every day 3 to 4 times per week 1 to 2 times per week 1 to 2 times per month Never or almost never
Are you tired during wake time?	Almost every day 3 to 4 times per week 1 to 2 times per week 1 to 2 times per month Never or almost never
Have you ever fallen asleep while driving?	Yes No
Do you have high blood pressure?	Yes No Do not know