Muenster FAMILY Medical Clinic

Amy Dangelmayr, FNP-C • Stephanie Rynor, FNP-BC

CONFIDENTIAL PATIENT INFORMATION

Date:_____

First Name:_____**Last Name:**_____**DOB:**_____

Mailing Address:_____

City:_____**State:**_____**Zip Code:**_____

Home Phone:_____**Cell Phone:**_____

Male:_____**Female**_____**Social Security Number:**_____

Email Address:_____

Circle One: Married Single Partnered Widowed

Name of Spouse/Partner/Significant other (if applicable):_____

Patient Employed By:_____**Business Phone:**_____

Name of Responsible Party:_____

Do you have health insurance? YES / NO

Emergency Contact:

Name:_____**Relationship:**_____**Phone:**_____

Muenster Family Medical Clinic, LLC
PO Box 647
Muenster, Texas 76252
940-759-2502

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PATIENT HEALTH HISTORY PG 1 of 2

Name_____**Age:**_____**Birthdate:**_____**Gender:**_____
Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed **Orientation:** ☐Heterosexual ☐Homosexual ☐Bisexual
Currently Living: ☐Alone ☐With Family ☐With Friends ☐With Significant Other
Profession (job):_____ ☐Working, Employed By:_____ ☐Retired

GENERAL
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Fatigue
- ☐ Difficulty Sleeping
- ☐ Forgetful

EYE, EAR, NOSE, THROAT
- ☐ Visual Changes
- ☐ Double Vision
- ☐ Ringing in the ears
- ☐ Hearing Loss
- ☐ Ear Pain
- ☐ Sinus Congestion or Pain
- ☐ Nosebleeds
- ☐ Hoarseness
- ☐ Difficulty Swallowing

DERMATOLOGICA
- ☐ Psoriasis
- ☐ Changes in moles
- ☐ Warts
- ☐ Rash

RESPIRATORY
- ☐ Wheezing
- ☐ Coughing
- ☐ Shortness of breath
- ☐ Emphysema/COPD

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Moody
- ☐ Irritable
- ☐ Suicidal thoughts

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Murmur
- ☐ Rapid Heartbeat
- ☐ Heart Attack

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Rectal Bleeding

MUSCLE, JOINT, BONE
- ☐ Muscle Pain
- ☐ Joint Pain
- ☐ Weakness
- ☐ Gout

NEUROLOGICAL
- ☐ Dizzy
- ☐ Loss of conciseness
- ☐ Siezures
- ☐ Numbness
- ☐ Frequent Headaches

ENDOCRINE
- ☐ Thyroid Problems
- ☐ Diabetes
- ☐ Hot Flashes
- ☐ Night Sweats
- ☐ Irregular Menses

QUESTIONS

Do you smoke?_____
_____Per Day
_____Per Week
_____Per Month

Do you smoke or use any form of THC? _____
If yes, what form? _____
How often?: _____

Do you vape? _____
If yes, how long? _____
How many cartridges per day? _____

Any other illicit drug use?
_____

Do you drink alcohol? ___
_____Per Day
_____Per Week
_____Per Month

Do you drink caffeine?___
_____Per Day
_____Per Week
_____Per Month

Do exercise?___
_____Per Day
_____Per Week
_____Per Month

Colonoscopy?___**Y**___**N**
Date:_____

Bone Density?___**Y**___**N**
Date:_____

MEN ONLY

Pain or lumps in testicles? ___**Y**___**N**

Penile (penis) itching, burning or discharge? ___**Y**___**N**

Prostate Disease or problems?___**Y**___**N**

Problems starting or stopping your urine stream? ___**Y**___**N**

Wake in the night to go to the bathroom?___**Y**___**N**

Sexual problems or concerns?___**Y**___**N**

WOMEN ONLY

Number of
_____ **pregnancies**
_____ **births**
_____ **miscarriages**
_____ **abortions**

Birth Control Method:
_____

Sexual problems or concerns?___**Y**___**N**

Vaginal itching, burning or discharge?___**Y**___**N**

Wake in the night to go to the bathroom?___**Y**___**N**

Mammogram?___**Y**___**N**
Date:_____

Date of last Pap Smear
_____

Hysterectomy?___**Y**___**N**
If yes, do you still have your ovaries? ___Y___N

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PATIENT HEALTH HISTORY PG 2 of 2

CONDITIONS: Check all you have or have had in the past

☐ AIDS	☐ Cancer	☐ HIV Postitive	☐ Thyroid Problem
☐ Alcoholism	☐ Cataracts	☐ Kidney Disease	☐ Tuberculosis
☐ Anemia	☐ Chemical Dependency	☐ Liver Disease	☐ Ulcers
☐ Anorexia	☐ Diabetes	☐ Migraine Headaches	☐ Sleep Apnea
☐ Appendicitis	☐ Emphysema	☐ Mononucleosis	☐ Sexual Transmitted Disease
☐ Arthritis	☐ Epilepsy	☐ Multiple Sclerosis	Type:_____
☐ Asthma	☐ Glaucoma	☐ Pacemaker	☐ Other (please list)
☐ Bleeding Disorders	☐ Goiter	☐ Pneumonia	_____
☐ Breast Lump	☐ Heart Disease	☐ Psychiatric Care	_____
☐ Bulimia	☐ Hepatitis	☐ Stroke	_____

SURGERIES/HOSPITALIZATIONS: List all Surgeries

Surgery	Year	Reason	Physician

MEDICATIONS: List all medications you take (including over the counter herbs and medications taken)

Medication	Strength	How Often	Reason

ALLERGIES: List all allergies (medications, foods)

Allergy	Physician

FAMILY HISTORY: List diseases and age of death

Family Member	Disease(s)	Age of Death
Father		
Mother		
Paternal Grandfather		
Paternal Grandmother		
Maternal Grandfather		
Maternal Grandmother		

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INSURANCE & CONSENT

ASSIGNMENT OF INSURANCE BENEFITS:

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my provider to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I, hereby authorize my insurance company to pay and hereby assign directly to Whitesboro Family Medical Clinic, LLC all benefit, if any otherwise payable to me for his/her services as described on the attached forms. I understand that I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Whitesboro Family Medical Clinic will be credited to my account, in accordance with the above said assignment. I also release all insurance/Medicare payments to go directly to Whitesboro Family Medical Clinic.

_____ _____

Authorized signature or subscriber Date

CONSENT TO BE EVALUATED AND TREATED BY A NURSE PRACTITIONER:

I understand that Whitesboro Family Medical Clinic, LLC employs nurse practitioners to deliver care, diagnosis and treatment of any illness or injuries that I have incurred, and that I can at any time refuse to see the nurse practitioner and see a physician elsewhere. I also understand that the clinic is staffed be nurse practitioners and that it will be necessary for me to travel to another facility for a physician appointment.

_____ _____

Signature Date

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REGISTRATION AND OFFICE POLICIES PG 1 of 3

We respectfully ask you to be prepared at the time of your visit. Any documents that require the healthcare provider's signature, we ask that you either submit those prior to your visit or bring them with you at the time of your visit.

PLEASE NOTE: For patients transferring from another medical practice, please come in prior to your visit and sign a records release, so we may have your records before your appointment.

PLEASE BE COURTEOUS: We appreciate and expect that you will treat our staff and health care providers with courtesy and respect. We reserve the right to dismiss you from the practice for non-compliance of this policy.

INSURANCE: We accept most major insurance plans; therefore it does come with certain limitations including that we must physically see you in order to prescribe medications or make diagnoses. Please be sure to bring your insurance card with you and alert the practice of any changes in your insurance status or mailing address. It is the responsibility of the patient to ensure Whitesboro Family Medical Clinic is a participating provider for your plan. You may still select our office for your medical care, but "out of network" benefits will apply. In that case, patients will be responsible for the full cost of their visit on the day of service and can submit a receipt for reimbursement to their insurance plan. It is not our responsibility to know or advise you on your insurance benefits. Patients with questions about their coverage should contact their particular insurance carrier's customer service department. Additionally, we do not accept cash pay patients.

FINANCIAL/PAYMENT POLICY: Whitesboro Family Medical Clinic does accept cash, checks or credit card payments for your convenience. Patients are required to pay the full amount of their co-pay, co-insurance or deductible fees at the time of the visit. It is understood and agreed that in the event if ab outstanding balance that is not paid by your insurance, you are personally responsible for the payments of all charges due. Checks can me written to Whitesboro Family Medical Clinic at the time of the visit. In the event of a returned check, there will be a $35.00 non-refundable fee in addition to the amount initially owed.

LATE ARRIVALS: Please call if you are running late or to let us know that you are on your way. If you are more than 15 minutes late for your appointment, we may ask you to reschedule for another time.

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REGISTRATION AND OFFICE POLICIES PG 2 of 3

NO SHOW/CANCELLATION POLICY: Your appointment is reserved especially for you. A missed appointment leaves an empty slot that could have been used by a patient in need of medical care. Not cancelling an appointment in a timely fashion is unfair to other patients. We, therefore, request that patients who are unable to keep their scheduled appointment notify us at least 24 hours in advance, so the time might be made available for someone else. Any missed appointments will result in a $35.00 no-show fee. Three missed appointments within 12 months may result in dismissal from our practice.

MULTIPLE CONCERNS AT A PHYSICAL/WELL VISIT: If your visit is scheduled for a physical/well visit, this is considered a general check-up. If you are sick, or needing prescription refills , this will be billed as a regular office visit as well as a physical/well visit, therefore, a co-payment will apply to those visits.

PRESCRIPTIONS: All prescription refills should be requested during regular office hours. Please have the pharmacy telephone number available when calling for the request. Any ADD/ADHD medications that require an in-office pick up, require 24 hours notice. Routine prescription refills will generally be phoned in within 24 hours. The medical provider will not routinely prescribe antibiotics over the phone without an examination.

LAB/PATHOLOGY RESULTS: Patients are responsible for all lab fees if insurance does not cover or apply balance to deductible. It is recommended that you check with your insurance to see if lab tests are covered. Most ROUTINE lab tests are covered, but some SPECIALTY labs are not always covered. Lab results will need to be discussed in the office with the provider. We have specific charges for lab tests for self-pay patients. If you choose to have lab tests submitted through your insurance or use a different lab/facility, your cost could be higher due to deductibles not being met or due to tests being a non-covered benefit under your plan.

EMERGENCY CARE: In the event of a serious emergency, you should go immediately to the nearest hospital emergency room or call 911. Should you have ab urgent matter, we will do our best to respond to your issue promptly. In a less serious situation that needs to be addressed, you may call the office and you will be contacted as soon as possible. If you have any doubt about the seriousness of the emergency, it is best to go directly to the emergency room.

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REGISTRATION AND OFFICE POLICIES PG 3 of 3

GROUNDS FOR TERMINATION: Whitesboro Family Medical Clinic may terminate a relationship with a patient at any time given a 30 days' notice for which the physician is only responsible for responding to urgent medical matters. Whitesboro Family Medical Clinic will reserve this action for patients who demonstrate a lack of respect for themselves and the practice by repeatedly missing appointments, failing to pay their bills, disregarding the stated policies of the practice, or acting in a way that is deceptive, dishonest or abusive.

_____ _____

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HIPPA ACKNOWLEDGEMENT AND CONSENT FORM

Patient Name:_____DOB:_____

I hereby give my consent to Whitesboro Family Medical Clinic, LLC to us and disclose protected health information about me to carry out our treatment, payment and healthcare operations. (The Notice of Privacy Practices provided by Whitesboro Family Medical Clinic, LLC, describes such uses and disclosures more completely and is continually posted on the wall in the waiting room at the PRACTICE)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Whitesboro Family Medical Clinic, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Amy Dangelmayr, FNP-C at Whitesboro Family Medical Clinic, LLC.

With this consent Whitesboro Family Medical Clinic, LLC may call my home or other alternative locations and leave a message on voicemail or in person in reference to items that assist the practice in carrying out TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results among others.

With this consent Whitesboro Family Medical Clinic, LLC may mail to my home or other alternative locations any items that assist the practice in carrying out TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS, such as statements.

With this consent Whitesboro Family Medical Clinic, LLC may email to my home or other alternative locations any items that assist the practice in carrying out TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS. I have the right to restrict how it uses or discloses my PHI to carry out TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS. This practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Whitesboro Family Medical Clinic, LLC to use and disclose my PHI to carry out TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS. I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Whitesboro Family Medical Clinic, LLC may decline to provide treatment to me.

_____ _____

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PROTECTED HEALTH INFORMATION DISCLOSURE

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM WHITESBORO FAMILY MEDICAL CLINIC, LLC MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, PLEASE FILL OUT THE LIST BELOW.

I give permission for my Protected Health Information to be disclosed for purposes of communication results, findings and care decisions to the family members and/or others listed below:

Name:_____**Phone:**_____

Name:_____**Phone:**_____

Patient/Representative may revoke or modify this specific authorization and that revocation or any modifications must be in writing.

_____ _____

Signature **Date**

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