6618 Sitio del Rio B-101 Austin, Texas 78730 Phone: 512.524.2336 Fax: 512.372.8525

ADULT MEDICAL HISTORY FORM

Name: _____ Sex: M F Date of Birth: _____ Age: _____
Last First Middle

I. PAST MEDICAL HISTORY

	Yes	No		Yes	No	
Heart Disease	❑	❑	Diabetes	❑	❑	Other: _____
Kidney Disease	❑	❑	Thyroid or Glandular	❑	❑	_____
Asthma & Lung	❑	❑	Cancer	❑	❑	_____
Liver, Hepatitis	❑	❑	Back/Spine Disorder	❑	❑	_____
Gastrointestinal	❑	❑	Rheumatic Fever	❑	❑	_____
Peptic Ulcer	❑	❑	Stroke	❑	❑	_____
Head Injury, Seizures	❑	❑	Migraines	❑	❑	_____
Psychiatric Disorder	❑	❑	Colon Disorder	❑	❑	_____
High Blood Pressure	❑	❑	HIV or AIDS	❑	❑	_____

II. PAST SURGICAL HISTORY

	Yes	No		Yes	No	
Cataract	❑	❑	Hernia	❑	❑	Other: _____
Ear Tubes	❑	❑	Hysterectomy (uterus)	❑	❑	_____
Tonsillectomy	❑	❑	Ovaries removed	❑	❑	_____
Thyroidectomy	❑	❑	Tubal ligation	❑	❑	_____
Breast Surgery	❑	❑	Vasectomy	❑	❑	_____
Heart Surgery	❑	❑	Knee Surgery	❑	❑	_____
Gallbladder	❑	❑	Hip Surgery	❑	❑	_____

III. MEDICATIONS

Regular Medications (include vitamins, over the counter, birth control, herbal meds)
(Example: Crestor,10 mg, 1 a day)

	Drug	Drug Strength	Frequency		Drug	Drug Strength	Frequency
1				6			
2				7			
3				8			
4				9			
5				10			

ALLERGIES TO MEDICATIONS / OTHER: _____

Immunizations: Hepatitis A_____ Hepatitis B_____ MMR_____ Varicella_____ IPV_____
Dtap/Td/TdaP_____ Pneumovax-23_____ Gardasil_____ Zostavax_____ PPD_____

GYN (Women only) Age menses began _____ Last menstrual period _____ Pregnancies _____
Full Term _____ Premature _____ Still Born _____ Abortion/Miscarry _____ Living children _____

IV. SOCIAL HISTORY

Marital Status: Married Single Divorced Widowed

Do you use tobacco? ❑ Yes ❑ No Type? _____ How much per day? _____ For how long? _____

Are you interested in quitting? _____

Alcohol ❑ Yes ❑ No How many drinks / week? _____

Caffeine ❑ Yes ❑ No How many drinks / day of: coffee tea soda

Currently sexually active? ❑ Yes ❑ No New partner in the last year? ❑ Yes ❑ No

Highest level of education? _____

Occupation? _____

Exposure to toxic chemical, work related injuries or stresses? _____

Military Service? _____

Foreign Travel (Where?) _____

Do you wear seat belts? Always Sometimes Never

Exercise Schedule? _____

Major changes, stresses in: Family 1 2 3 4 5 (L ⟶ H) Finances 1 2 3 4 5 (L ⟶ H) Work 1 2 3 4 5 (L ⟶ H)

V. FAMILY HISTORY

		IF LIVING		**IF DECEASED**
	Age	Health	Age	Cause of Death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brothers/	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
	_____	_____	_____	_____
Children	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Do you have a family history of: (Circle any that apply and explain below, include blood relatives only)

Diabetes	Cancer	Heart Disease	High Blood Pressure
Peptic Ulcer	Stroke	Heritable Disorder	Rheumatoid Arthritis
Epilepsy	Gout	Tuberculosis	Glaucoma
Alcohol/Drug Abuse	Kidney Disease	Migraines	Asthma/Lung Disease
Colon Disease	Blood Disease	Mental Illness	Sickle Cell Anemia

Please indicate which family member (include maternal or paternal) is/was affected and any details:

_____

_____

_____

The above is complete and true to the best of my knowledge. I, the undersigned, voluntarily consent and grant permission to the physician to perform tests, treatments and procedures as indicated for myself or the above named minor for as long as I am a patient of the physician.

_____ _____ _____ _____

Patient's Signature Date Reviewed by Date

AUTHORIZATION OF DISCLOSURE OF CONFIDENTIAL INFORMATION

(Medical Records Release Form)

This Authorizes: _____

_____

Phone: _____ Fax: _____

to provide a copy, summary, or narrative of my medical records (as indicated by the check mark(s) below) or otherwise release confidential information. I agree that a photocopy of this authorization may be considered valid.

- ❑ Complete record
- ❑ Records of care from the following dates: _____to_____
- ❑ Records concerning the following conditions:_____
- ❑ Other, Please specify:_____

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS/HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.
Patient Signature:_____Date:_____

The reasons or purpose for this release of information are as follows:

- ❑ Medical Care
- ❑ Attorney
- ❑ Specialist
- ❑ Insurance
- ❑ Changes in Medical Provider
- ❑ Other_____

Release the information to: Texas Family Physicians @ River Place
Dr. Martin C. Molina
6618 Sitio Del Rio Blvd.
Building. B, Ste. 101
Austin, Texas 78730
Phone: 512-524-2336 Fax: 512-372-8525

Patient Name(s) Date of Birth: Social Security Number:

_____
_____
_____
_____

Patient/Guardian Signature:_____ Date:_____

PATIENT INFORMATION

Name_____Nickname_____DOB_____ SS#_____

Address_____City_____Zip_____

Home _____Work _____ Cell_____

Sex: □ M □ F □Married □ Divorced □Single □Minor □ Partnered for ___years

Patient employer/School_____ Occupation:_____

Employer/School Address:_____

Whom may we thank for referring you?_____

In case of an emergency who should be notified? _____Phone_____

PRIMARY INSURANCE

Person Responsible for Account_____Relation to Patient: □ Self □ Spouse □ Dependent

DOB:_____Soc.Sec.#_____ Phone_____

Address (if different from patient)_____City/State/Zip_____

Person Responsible employed by_____Occupation_____

Business Address_____ Phone_____

Insurance Company:_____Contact number:_____

Subscriber ID#_____Group #_____

Claims Address_____

SECONDARY INSURANCE

Is the patient covered by another insurance?_____

Subscriber Name_____

DOB:_____Phone_____

Insurance company_____

Contact #_____

Claims Address_____

_____

ID#_____

Group #_____

PHARMACY INFORMATION

Which pharmacy do you use? _____

Phone/Location_____

Do you use a mail order company? □ Yes □ No

Company Name_____

Phone_____

Fax_____

ID Number_____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with the above mentioned insurance company, and assign directly to Texas Family Physicians @ River Place all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Texas Family Physicians @ River Place may use my health care information and my disclose information to the above Insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end one year from the date signed below.

_____ _____

Signature of Patient or Responsible Party Date Signed

_____ _____

Please print name of Patient/Responsible Party Relationship to Patient

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MEDICAL INFORMATION RELEASE

This section authorizes Texas Family Physicians @ River Place to discuss non-sensitive medical information (such as lab test results, appointment verification, etc) with: (please check appropriate box)

Patient Only
Spouse - Specify Name of Spouse:_____
Parent - Specify Parent Name:_____
Other (please specify) _____

TEST RESULTS: ("X" please mark one or all desired)

____ Please leave a message with lab results.
____ Do not leave lab results on the voicemail. I (the patient or parent) will return your call to discuss the results

OFFICE POLICIES

All co-pays are due before your appointment. All other payments are expected at the time of service unless prior arrangements have been made.

A $25.00 fee may be assessed for missed appointments. Please call 24 hours prior to your appointment if you are unable to make it.

We are only using Clinical Pathology Laboratories (CPL) for the labs that are sent out. If your insurance company requires that we use another lab, it is your responsibility to let us know before your appointment.

Please let the receptionist know of any changes in your information (such as insurance, address, phone) before your appointment.

If you need a refill on medication, please call your pharmacy and have them fax us a refill request.

Please allow 2-4 business days on all requests (faxed refills request, ADHD medication refills, referrals, etc)

WAIVER OF LIABILITY

There may be certain services that are not adequately covered by your insurance company. If the provider feels that this service is medically necessary and your insurance company denies payment, it will be your responsibility to pay for that service. This includes all services rendered including but not limited to laboratory service performed in house or sent to an out side lab.
This section is valid for any date of service from date signed.

_____ _____
Patient Name Printed Date of Birth

_____ _____
Signature of Patient or Responsible Party Date Signed

(Please note you will need to re-sign this form whenever changes are made and/or no later than 1 year from original date signed).

6618 Sitio del Rio B-101 Austin, Texas 78730 Phone: 512.524.2336 Fax: 512.372.8525

Notice of Privacy Practices

Texas Family Physicians
6618 Sitio Del Rio Blvd.,
Bldg B, Ste #101
Austin, Texas 78730
Phone: 512.524.2336
Fax: 512.372.8525

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information as described in this notice.

period for the requested information. You may not request this information for any dates prior to April 14, 2003(the compliance date for the federal regulation) nor for a period of time greater than six years (our legal obligation to retain information). Your first request within a 12-month period will be free. There will be a cost for any additional requests. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications: You have the right to request how we communicate with you to preserve your privacy. For example- you may request that we only call you at work, etc. Your request must be made in writing. We will accommodate all reasonable requests.

File a Complaint: If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our office manager or directly to the Secretary of Health and Human Services. To file a complaint with our office, you must submit it in writing within 180 days of the suspected violation. You should know that there would be no retaliation for your filing a complaint.

For more information: You may ask our receptionist for additional information to read or contact our office manager. Please sign and return the attached form to our receptionist upon reading this brochure.

You must submit this request in writing to our office manager, stating exactly what information is incomplete or inaccurate and your reasoning that supports your request. We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if:
- the information was not created by us, or who created it is no longer available to make the amendment;
- the information is not part of the record which you permitted to inspect and copy;
- the information is not part of the designated record set kept by this practice; or if it is the opinion of the health care provider;
- the information is accurate and complete.

Request Restrictions: You are able to request a restriction or limitation of how we use or disclose your information. For example- request us not to release information about prior treatment to a family member or someone who may be involved in your care or payment for care. You must submit this request in writing to our office manager. We are not required to agree to your request if we feel it is in your best interest to use or disclose your information. However, if we agree, we will comply with your request unless that information is needed for emergency treatment.

An Accounting of Disclosures: You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for treatment, payment, or health care operations. Your request must be in writing and must state the time

Ways in Which We May Use and Disclose Your Protected Health Information:

We assure that all of the ways we are permitted to use and disclose your health information fall within one of the following categories. We have provided an example for each category, but these examples are not meant to be exhaustive.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. Additionally we may disclose your health information to another physician who we have requested to be involved in your care. We will also disclose your health care information to a specialist to whom we referred you.

Payment: We will use and disclose your protected health information to obtain payment for the services we provide you. For example- We may enclose information with a bill to a third- party payer that identifies you, your diagnosis, procedures performed and supplies used in rendering the service.

Health Care Operations: We will use and disclose your protected health information to support the business activities of our practice. For example-we may use medical information about you to review and evaluate our treatment and services, and our staff's performance.

Other Ways We May Use and Disclose Your Protected Health Information:

Appointment Reminders: We will use and disclose your protected health care information to contact you as a reminder about scheduled appointments or treatment.

Treatment Alternatives: We will use and disclose your protected health care information to tell you about or to recommend possible alternative treatments or options that may be of interest to you.

Others Involved in Your Care: We will use and disclose your protected health information to a family member, a relative, or any other person that you identify that is involved in your medical care or payment for care.

Research: We will use and disclose your protected healthcare information to researchers if the research proposal and protocols to ensure privacy have been reviewed by an institutional review board.

As Required by Law: We will use and disclose your protect health information when required to by federal, state, or local law. You will be notified of any such disclosures.

To Protect Public Health and or Safety: We will use and disclose your health information to a public health authority that is permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. We may also disclose you information to a foreign government agency, if directed by the public health authority.

Inmates: We will use and disclose your health information to a correctional institution or law enforcement official. This information would be necessary for the institution to provide you with health care; to protect the heath and safety of others; or the safety and security of the correctional institution. **Your Health Information Rights** Although your health record is the physical property of the heath care practitioner or facility that compiled it, the information is yours. You have the right to:

Inspect and Copy: You have the right to inspect and copy the protected health information, for as long as we maintain that information. Your protected health information includes medical & billing records, as well as any other records we use to make decisions about you. Any psychotherapy notes about you are not available for your inspection or copying by law. TFP charges $25.00 for copying, mailing, or any other supplies used in fulfilling your request. If you wish to inspect or copy your medical information, you must submit your request in writing to our office manager. We will have 30 days to respond to your request for information that we maintain in our office. If the information is stored off- site, we are allowed 60 days to respond but we will inform you of this delay.

Request Amendment: You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. Please contact our Office Manager- Michelle Boyd 512-524-2336

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of Texas Family Physicians Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Name of Patient (Print)

_____

Signature of Patient or Personal Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____

Name of Patient or Personal Representative (Please Print)

_____

Date

Texas Family Physicians reserves the right to modify the privacy practices outlined in this notice.