Morgan Family Medicine

New Patient Medical History and Physical Form

Today's Date: _____

Name: _____ Date of Birth: _____

Reason for your visit: _____

Personal Medical History: Have you ever had any of the following conditions? (Check all that apply)

☐ Anemia ☐ Arthritis ☐ Asthma ☐ Cancer Type: _____ ☐ Chronic Obstructive Pulmonary (COPD) ☐ Clotting Disorder ☐ Congestive Heart Failure (CHF)	☐ Crohn's Disease ☐ Depression ☐ Anxiety ☐ Suicidal ☐ Diabetes ☐ Emphysema ☐ Endocrine Problems ☐ GERD ☐ Glaucoma ☐ Hepatitis ☐ HIV/AIDS	☐ Hypertension (High Blood Pressure) ☐ Kidney Disease ☐ Myocardial Infarction (Heart Attack) ☐ Peptic Ulcer Disease ☐ Seizures ☐ Stroke ☐ Ulcerative Colitis ☐ Kidney Stones ☐ Urinary Tract Infections (UTI)

Personal Surgical History: Have you ever had any of the following surgeries? (Check all that apply)

☐ Adrenal Gland Surgery ☐ Appendectomy ☐ Bariatric Surgery Type: Date: Gastric Bypass _____ Gastric Sleeve _____ ☐ Bladder Surgery ☐ Breast Surgery ☐ Breast Augmentation	☐ Colon Surgery ☐ Coronary Artery Bypass Graft ☐ Esophagus Surgery ☐ Hemorrhoid Surgery ☐ Hernia Repair ☐ Hysterectomy Date: _____ ☐ Cesarean Section ☐ Cholecystectomy (Gallbladder)	☐ Stomach Surgery ☐ Small Intestine Surgery ☐ Kidney Surgery ☐ Prostate Surgery ☐ Thyroid Surgery ☐ Neck Surgery ☐ Spine Surgery ☐ Other: _____

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Fax: (281)592-8001

117 South William Barnett Ave.,
Suite A
Cleveland, TX 77327

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Medications/Dosage/Frequency (Current):

_____

_____

_____

Allergies/Reactions:

- ☐ None
- ☐ _____

  _____

  _____

Family History: Has anyone in your family had any of the following conditions? (Check all that apply. If applies, indicate the relationship to you)

☐ Cancer: Colon _____ Rectum _____ Anal _____ Stomach _____ Breast _____ Prostate _____ Uterus _____ Ovarian _____ Thyroid _____ Blood _____ Lymphoma _____ Other _____	☐ Hepatitis _____ ☐ Anemia _____ ☐ Diabetes _____ ☐ Blood Clots _____ ☐ Heart Disease _____ ☐ High Blood Pressure _____ ☐ Anesthesia Reaction _____ ☐ Bleeding Problems _____

Social History:

Alcohol Use:	Never	Occasionally	Daily	Type _____
Tobacco Use:	Never	Previously, but quit	Packs Per Day _____ for _____ years	
Drug(s) Use:	Never	Occasionally	Daily	Type _____
Marital Status:	Single	Married	Divorced	Widowed Separated
	Name of spouse or significant other: _____			
Children:	Number of Children _____		Number of Grandchildren _____	

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Women: Number of Pregnancies _____ Number of Deliveries _____

Vaginal _____ C-Sections _____ Miscarriages _____

VIP's (abortions) _____

Cancer Health Habits: (Circle Response)

Women:		**Men:**	
Breast: Monthly Self-exam	Y N	Prostate: Yearly Rectal Exam	Y N
Yearly Physician Exam	Y N	Yearly PSA Blood Test	Y N
Last Mammogram _____	Y N	**All:**	
GYN: Yearly Exam	Y N	Skin: High Sun Exposure	Y N
Yearly PAP Exam	Y N	Yearly Skin Exam	Y N
Colon:			
Yearly Rectal Exam	Y N		
Yearly Stool Test for Blood	Y N		
Date of Last Colonoscopy	_____		

Patient Safety:

Do you feel safe in your home? Y N

Do you feel as if anyone is going to hurt you in your home? Y N

If you feel that someone will hurt you in your home, who? _____

For Office Use Only

B/P: _____/_____ **Pulse: _____** **Temp: _____**

Weight: _____ **Glucose: _____**

Nurses Notes:

_____

_____

_____

_____

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Morgan Family Medicine

Medical Consent and Authorization for Treatment

Patient Name: _____ Phone #: _____

DOB: _____

Consent for Services:

I _____ consent to medical treatment from Morgan Family Medicine for _____.

(Name of Patient)

I consent to allow the release of medical information when needed for treatment, payment and for state agencies.

I allow Morgan Family Medicine to speak for me when working with insurance companies on my eligibility.

I allow Morgan Family Medicine to do procedures and treatments per orders of Nurse Practitioners.

I have received a copy of Privacy Practice from Morgan Family Medicine.

I have received a copy of the Privacy Practice from Morgan Family Medicine.

My signature below shows that I understand and agree with the above information and age consent for all healthcare services by Morgan Family Medicine.

_____ _____

Patient or Representative Date

_____ _____

Relationship to Patient Reason Patient Can't Sign

_____ _____

Witness Date

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Morgan Family Medicine

General Information Sheet

Patient Information:

Patient's Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone#: _____

Email Address: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Social Security Number (SSN): _____ - _____- _____

Preferred Pharmacy:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Emergency Contact Information:

Name: _____ Phone Number: _____

Relation to Patient: _____

Medical Information Release:

My Medical information can be released via phone or in person to the following person(s):

Name: _____ Phone Number: _____

Address: _____

Name: _____ Phone Number: _____

Address: _____

Phone: (281)592-8000
Fax: (281)592-8001

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Authorization to Release Healthcare Information

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ SS#: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: Morgan Family Medicine

Address: 117 South William Barnett Ave.

City: Cleveland State: Texas Zip Code: 77327

This request and authorization apply to:

- ☐ Healthcare information relating to the following treatment, condition and/or dates:

  _____
  _____
  _____
  _____

- ☐ All healthcare information
- ☐ Other:

  _____
  _____
  _____
  _____

Signature of Responsible Party: _____ Date: _____

Phone: (281)592-8000
Fax: (281)592-8001

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Morgan Family Medicine

Financial Policy/Payment of Services

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager or call our billing company, MYEMED at 1-877-769-3633. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Payment in full is due at the time of service unless your health insurance carrier has made prior arrangements. For your convenience we accept checks, cash or credit cards (i.e.; VISA, Mastercard, Discover and American Express)

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept and assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment. If your insurance requires a referral it is your responsibility to provide the referral to our office prior to seeing the physician. If unable to provide the referral prior to the visit payment in full will be required at the time of the visit.
- If you have Medicare, Part B only you are responsible for your Medicare deductible and your 20% of the charges at the time of service.
- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of service.
- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- Morgan Family Medicine charges a $30.00 fee for failure to cancel your appointment within 24 hours of your scheduled appointment time.
- Morgan Family Medicine charges a $50.00 NSF fee for all returned or stop payment checks. In the event that you have two (2) NSF checks, Morgan Family Medicine will require you to pay cash for all copays and visits.

Signature of Responsible Party: _____ Date: _____

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Morgan Family Medicine

If your blood glucose is over 400 take 15 units Regular Insulin and contact our office immediately or go to the closest ER.

Weekly logbook

Target blood glucose ranges

Fasting: _____ mg/dL **to** _____ mg/dL

Pre meal: _____ mg/dL **to** _____ mg/dL

Post meal: _____ mg/dL **to** _____ mg/dL

Week of:

			Breakfast		Lunch		Dinner		Bedtime	
			Pre	Post	Pre	Post	Pre	Post	Pre	Post
Sun.	Comments:	Blood sugar:								
		Time:								
		Meds:								
		Carbs:								
Mon.	Comments:	Blood sugar:								
		Time:								
		Meds:								
		Carbs:								
Tues.	Comments:	Blood sugar:								
		Time:								
		Meds:								
		Carbs:								
Wed.	Comments:	Blood sugar:								
		Time:								
		Meds:								
		Carbs:								

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Thurs.	Comments:	Blood sugar:								
		Time:								
		Meds:								
		Carbs:								
Fri.	Comments:	Blood sugar:								
		Time:								
		Meds:								
		Carbs:								
Sat.	Comments:	Blood sugar:								
		Time:								
		Meds:								
		Carbs:								

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Weekly logbook

Blood Pressure/ Pulse

Week of:

			Morning		Afternoon		Bedtime		Symptomatic Time	
			Pre	Post	Pre	Post	Pre	Post	Pre	Post
Sun.	Comments:	Time								
		B/P								
		Pulse								
		Intervention								
Mon.	Comments:	Time								
		B/P								
		Pulse								
		Intervention								
Tues.	Comments:	Time								
		B/P								
		Pulse								
		Intervention								
Wed.	Comments:	Time								
		B/P								
		Pulse								
		Intervention								
Thurs.	Comments:	Time								
		B/P								
		Pulse								
		Intervention								
Fri.	Comments:	Time								
		B/P								
		Pulse								
		Intervention								
Sat.	Comments:	Time								
		B/P								
		Pulse								
		Intervention								

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Morgan Family Medicine

Patient Scheduling Appointment

Date: _____ Time: _____

Patient Information:

Name: _____ Date of Birth: _____
Address:_____
City: _____ State: _____ Zip code:_____
Home Phone#: _____Cell Phone#: _____
Email:_____

Reason for Appointment:

Symptoms:

_____
_____
_____

Form of Payment:

- ☐ Cash
- ☐ Insurance

Insurance Information:

Primary Insurance: _____
ID#: _____ Group#: _____
Policy Holder's Name: _____ Date of Birth:_____
Policy Holder's SS#: _____ Effective Date: _____
Secondary Insurance: _____
ID#: _____ Group#: _____
Policy Holder's Name: _____ Date of Birth: _____
Policy Holder's SS#: _____ Effective Date:_____

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Morgan Family Medicine

Tele-Health

Date: _____ Time: _____

Patient Information:

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip code:_____

Home Phone#: _____ Cell Phone#: _____

Email: _____

Pharmacy Information:

☐	Walgreens	Cleveland, TX	(281)592-0491
☐	CVS	Cleveland, TX	(281)592-5279
☐	Cleveland Pharmacy	Cleveland, TX	(281)593-3800
☐	Wal-Mart	Cleveland, TX	(281)592-2636
☐	Brookshire Brothers	Cleveland, TX	(281)592-5257
☐	Other: _____		

Notes: _____

Symptoms:

_____

_____

_____

Allergies:

_____

_____

_____

Med(s) ordered:

_____

_____

_____

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RETURN TO WORK OR SCHOOL

Date: _____

This certifies that _____ has been under my professional care for the following:

_____
_____
_____
_____
_____

He/She is cleared to return to work/school on: _____

Notes:

_____
_____
_____
_____
_____

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Morgan Family Medicine

Follow up Care Policy & Procedure

Receiving Test Results and Lab Results from Morgan Family Medicine

The office will only make three (3) attempt to reach a patient via phone.

Abnormal lab value refers to a result that falls outside of a pre-determined normal range.

Abnormal test results are not necessarily clinically significant or critical results.

Normal lab value refers to a result that falls within a pre-determined normal range.

Critical values - Test results that fall significantly outside the normal range and/or may represent life-threatening values, requiring rapid communication of results to the responsible caregiver. A delay in action on the result may result in an adverse outcome for the patient.

Clinically Significant Test Result is a result determined by a licensed provider based on his or her clinical judgment which requires follow-up with appropriate urgency. A licensed provider will determine clinical significance based on his or her knowledge of the patient's symptoms, previous test results, and/or diagnosis.

Follow-up - clinically appropriate action taken following receipt of a patient's test results

Authorized staff – Medical Assistants, or CNAs.

Licensed caregiver – Registered Nurses, LVNs

Licensed provider: MD, Physician Assistant, or **Nurse Practitioner**

Scope/Purpose: To provide a consistent, orderly process for the ordering and tracking of lab tests ordered by a licensed provider.

POLICY: Accurate diagnosis of clinical conditions and efficient treatment requires appropriate tracking of necessary medical labs and timely follow up on results.

PROCEDURE:

For the communication of Lab results, per the provider's orders:

1. A clinical staff member will attempt to contact the patient or legal guardian three (3) times via phone. After three attempts it is the patient's responsibility to contact provider for results.
2. At the provider's discretion, an appointment may be required to discuss lab results.
3. All communication (or efforts to communicate) will be documented within the patient's medical record typically in the notes section of the lab result window or within a telephone encounter.

Signature of Responsible Party: _____ Date: _____

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Referral

Doctor's name & Address	Work Phone	
	Other Phone	
	Reference #	

Patient Name		Date					
Age		First visit on		Sex		D O B	
Referral for							
Major complaint							
Diagnosis							
Special Instructions							
Referring Doctor's Comments							

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Morgan Family Medicine

HIPAA PRIVACY POLICY

A. Inspection and Copies of Protected Health Information

You may inspect and/or copy health information that is within the designated resort set, which is information that is used to make decisions about your care. Texas law requires that a request for copies be made in writing and we ask that request for inspection of your health information also be made in writing. Please send your request to the person listed at the end of this document. We may ask that a narrative of that information be provided rather than copies. However, if you do not agree to our request, we will provide copies. We can refuse to provide some of the information you ask to inspect or ask to be copied for the following reasons: The information is psychotherapy notes; the information reveals the identity of a person who provided information under the promise of confidentiality; the information is subject to the Clinical Laboratory Improvements Amendments of 1988; the information has been compiled in anticipation of litigation. We can refuse to provide access to our copies of some information for the other reasons, provided that we arrange fro review of our decision to deny access. Texas law requires us to be ready to provide copies or a narrative report within 15 days of your request. We will inform you when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing. HIPAA permits us to charge a reasonable cost-based fee.

B. Amendments of Medical Information

You may request and amendment of your medical information in the designated records sent. Any such request must be made in writing to the person listed at the end of the document. We will respond within 60 days of your request. We may refuse to allow and amendment for the following reasons: The information was not created by this practice or physicians in this practice; the information is not part of the designated records set; the information is not available for inspection because of an appropriate denial; the information is accurate and complete. Eve if we refuse to allow and amendment, you are permitted to include a patient statement about the information at issue tin your medical records.

C. Accounting of Certain Disclosures

HIPPA privacy regulations permit you to request, and us to provide, and accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by our or your representative. Please submit any request for an accounting to the person at the end of this document. Your first accounting of disclosures will be free within a 12 month period. For additional requests within the period we are permitted to charge fro the cost of providing the list. If there is a charge we will notify you , and you may choose to withdraw or modify your request before any costs are incurred.

D. Appointment Reminders, Treatment Alternatives, and other Benefits

We may contact you by telephone, email/mail or both to provide appointment reminders, information about treatment alternatives, or other health related benefits and services that may be of interest to you.

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E. Complaints

If you are concerned that your privacy rights have been violated, you may contact the entity listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. We will not retaliated against you for filing a complaint with us or the government.

F. Our Promise to you

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of your privacy practices with respect to protected health information, and to abide by the terms of notice of privacy practices in effect.

G. Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to rights described above, please contact our office at (281)592-8000.

I acknowledge that I have been given an opportunity to review Morgan Family Medicine's Notice of Privacy Policies and have been provided a copy if I desire one.

_____	_____	_____
Signature of Patient or Legal Representative	Relationship to Patient	Date

Your Birthday and address will be used to verify your identity on your behalf.

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